

Adolescents' Evaluation of Dialectical Behaviour Therapy

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ABSTRACT

There is a large amount of research on BPD which highlights the pervasive and distressing nature of this disorder along with its resulting high financial cost to services. Previous research exploring intervention options for BPD have found DBT to be beneficial in reducing parasuicidal behaviour and it is acknowledged as the intervention of choice for adults. The research evidence on 'what works' for adolescents with BPD is limited, although DBT is an intervention offered in clinical practice. This study aims to contribute to the research on the effectiveness of DBT by exploring adolescents' experience of receiving this therapy.

Five participants took part in the study and verbatim transcripts from their interviews were analysed using Thematic Analysis. The aim of the analysis was to develop understanding on what adolescents found to be the most and least helpful aspects of DBT and to help ascertain whether participants viewed this therapy as effective in reducing their presenting difficulties.

Results identified four main themes which were constructed from the data set; 'Clinical Picture', 'Deciding to start DBT', 'Evaluation of DBT' and 'Change', with each theme containing between two and six sub-themes. The themes were seen to connect with each other to represent participants' journey through therapy.

Clinical implications of the research indicate that clinicians play an important role in the process of therapy and contribute to both positive and negative experiences. It appears there is a need for clinicians working with this client group to be appropriately trained and

skilled to provide flexible care. In addition the findings from the current study suggest DBT did not target the multiple and varied problems the adolescents presented with, resulting in on-going difficulties and high levels of disengagement and drop-out rates. Whilst participants felt the intervention contained positive elements, overall they reported dissatisfaction with the outcome of therapy. Services may therefore need to consider alternative or additional intervention options to target adolescents' presenting difficulties and help improve their quality of life.

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CHAPTER ONE: INTRODUCTION

This chapter explores the relevant literature on Borderline Personality Disorder (BPD) and available intervention options. In particular, consideration is given to an adolescent population and the recommended treatment of choice for BPD, Dialectical Behaviour Therapy (DBT). The literature presented provides the context for the current study which explores adolescent experience of DBT. The rationale for the study is discussed along with the aims and objectives of the research.

1.1 Personality

Personality is currently understood as a complex combination of various traits which are unique to each individual (Livesley, 2001). Personality researchers over the past 40 years have consistently found that personality can be best understood through five broad factors; this theoretical construct is currently known as the Five-Factor Model (FFM) of personality or the 'Big Five' (Digman, 1990). The FFM consists of traits of extraversion (positive emotionality), neuroticism (negative emotionality), agreeableness, conscientiousness and openness to new experiences. These traits are present, to a greater or lesser extent in each individual, creating a unique personality.

Over the years many theories have been put forward to explain the development of personality with the predominant view that personality traits a) account for individual behaviour, b) are determined in childhood and adolescence, and c) are fully developed by the age of 30 (McCrae & Costa, 1994). These beliefs resulted in the traditional psychiatric perspective that by late adolescence personality was a stable construct and therefore personality disorders were 'untreatable'.

More recently the development of personality has been explained through a combination of genetic and environmental influences and interactions. Walter Mischel has been an important contributor to the research exploring the impact of interactions on personality development, rather than considering personality traits alone as an explanation of behaviour. He proposed that personality was not a fixed, stable construct, instead was a function of personality traits and cognitive-affective processes interacting with different situations (Mischel, 1968 & 2009). Such interaction theories have helped develop an argument against the early stability of personality which relates to the associated notion of 'treatability'.

There is still debate regarding the stability or plasticity of personality, however the idea of personality disorders being 'untreatable' has been challenged in recent years as a result of interaction theories and research to suggest that traits can increase or decrease over time (Branje, 2007; Caspi, 1998; Caspi, Roberts, & Shiner, 2005). Evidence for the treatability of personality disorder has also been supported by a government policy document entitled 'Personality disorder: No longer a diagnosis of exclusion' (NIMHE, 2003). This policy refuted the commonly held belief that psychological interventions were not effective for PD and instead suggested:

"there are real grounds for optimism that therapeutic interventions can work for personality disordered patients" (p.23).

1.2 Personality Disorders

Personality disorders are a common mental health difficulty with the prevalence in Great Britain estimated at 1 in 20 (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006). Personality disorders impact on how a person manages their feelings and how they relate to other people. They can be disabling conditions associated with significant dysfunction and distress. However there is a large variation in severity and the amount of dysfunction caused, with some people with a personality disorder (PD) never accessing services whilst others are frequent attendees (NIMHE, 2003).

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR) (American Psychiatric Association, 2000) defines a personality disorder as:

“an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment”

Personality disorders have been associated with adverse childhood events such as abuse, neglect or trauma. It is thought that a combination of these environmental factors along with inherent biological characteristics (a gene-environment interaction), can result in the development of a personality disorder (Caspi et al., 2005; NIMHE, 2003).

The onset of a PD is believed to be most likely to occur in adolescence, with such onset required to meet diagnostic criteria. However adolescence, as identified within a western culture, has been noted as a critical development stage with a rise in psychiatric problems,

behavioural difficulties and conflict during this time. It is believed this rise is due to factors such as puberty, an increasing need for autonomy and demands to conform with peer group behaviour (Smith, Cowie, & Blades, 2003); research suggests the demands and stressors during this developmental stage can lead to an increase in dysfunctional and dysregulated behaviour (Pulkkinen, 2001). In addition Erikson (1968) suggests adolescence is a key development stage in terms of identity formation, with identity 'crisis' occurring before a resolution is found. Throughout this stage adolescents may experiment with different roles, ideals and behaviours before a coherent and acceptable identity is formed. During this time problems can arise and result in contact with services, for example difficulties in peer and parent relationships, social isolation, social skill deficits and mental health difficulties such as anxiety, depression & self-harm.

The difficulties arising during the adolescent stage of development therefore overlap with some of the characteristics required for a diagnosis of PD and more specifically, BPD (e.g. interpersonal difficulties, dysfunctional behaviour, self-harm). This leads to concerns regarding accurate diagnosis, particularly in light of the debate regarding the usefulness of a categorical approach, as discussed below.

The DSM-IV-TR currently has ten categories of personality disorder split into three clusters; however there is on-going debate regarding the usefulness of this categorical approach with some researchers and clinicians considering a dimensional approach to be a more accurate conceptualisation of personality and PD (De Clercq, De Fruyt, & Widiger, 2009; Livesley & Jang, 2005; Markon, Krueger, & Watson, 2005; O'Connor, 2002; Trull & Durrett, 2005; Widiger & Corbitt, 1994).

The current categorical approach identifies a personality disorder as either being present or absent based on the identification of associated traits. Each PD category contains between seven-to nine traits, of which approximately five are needed to be present for a diagnosis. This heterogeneity results in a large variation of presentation for the same diagnosis. For example, to diagnose BPD five out of nine traits must be identified, resulting in at least 126 different ways a person could meet diagnostic criteria (Asnaani, Chelminski, Young, & Zimmerman, 2007). This approach also implies there is a difference between 'normal' personality and a diagnosed personality disorder. However research indicates there is little difference between a person who does or does not meet diagnostic criteria (e.g. four traits instead of five traits (Markon, Krueger, & Watson, 2005; O'Connor, 2002; Widiger & Corbitt, 1994). This suggests that not only is there large heterogeneity between BPD individuals, it is difficult to differentiate between individuals who do or do not meet the arbitrary number of traits needed for diagnosis. These difficulties raise concerns when considering research conducted to explore treatment approaches.

The Department of Health has acknowledged such problems with the categorical approach to diagnosis and describe it as "unwieldy" (NIMHE, 2003). A dimensional approach is therefore becoming widely acknowledged as a more accurate conceptualisation of personality disorder; personality traits are described on a continuum with personality disorders being viewed as extreme examples or maladaptive forms of these traits (Distel et al., 2009; Livesley & Jang, 2005). As a result of this debate, the DSM-5 (to be published in 2013) is considering the adoption of a 'hybrid dimensional-categorical approach'. In addition the DSM-V is considering the reduction of PD categories from ten to six, these six will include; Borderline, Obsessive-Compulsive, Avoidant, Schizotypal, Anti-social and Narcissistic Personality Disorder along with Personality Disorder Trait Specified (American Psychiatric Association, 2011).

Whilst a shift to a more dimensional model can be viewed as positive, resulting in a more accurate account of individual traits and difficulties, there are concerns that the hybrid system proposed is not based wholly on empirical evidence and will result in the DSM-5 being incompatible with its predecessor (Livesley, 2012). In addition there are concerns that incorporating a dimensional model will reduce the clinical utility of the DSM, as current diagnostic labels are familiar and subsume relevant clinical information relating to prognosis and treatment (Skodol, 2012). Although the current DSM classification system is deemed unsatisfactory, consensus is yet to be reached on how to improve this, with the current DSM-5 proposals still a work in progress (Skodol, 2012). Whilst the changes proposed and the potential use of a more dimensional approach are important considerations, the categorical approach is still predominantly used in clinical and research settings and as such will be the classification system considered in the current study.

The current ten categories and three clusters of PD identified in the DSM-IV-TR are:

Cluster A: Characterised by odd or eccentric behaviour, this cluster includes paranoid, schizotypal and schizoid personalities. A person with a Cluster A personality often presents with behaviour difficult to understand by others; they may be suspicious and distrustful of others and live in their own 'fantasy world'. Cluster A personalities are associated with the lowest levels of service use, when compared to the other two clusters (Lenzenweger, Lane, Loranger, & Kessler, 2007).

Cluster B: Characterised by erratic, emotional and dramatic behaviour, this cluster includes anti-social, borderline, histrionic and narcissistic personalities. A person with a Cluster B Personality may find it difficult to regulate their emotions and often have fluctuating moods

and beliefs. They can be viewed by others as dramatic and unpredictable. Cluster B personalities have been found to be associated with the highest levels of comorbid axis one disorders such as anxiety, PTSD and depression, as well as the highest levels of distress and social impairment (Lenzenweger et al., 2007). This cluster is also associated with the highest levels of service use, particularly from a young age (Coid et al., 2006).

Cluster C: Characterised by anxiety and fearful behaviour, this cluster includes avoidant, dependent and obsessive-compulsive personalities. A person with a Cluster C Personality can often feel overwhelmed by anxiety or fear. They can be viewed by other people as withdrawn and avoidant. Cluster C has been found to be the most prevalent in the general population (Coid et al., 2006). Although associated with low levels of service use, when services are accessed cluster C personalities have the highest levels of treatment response (Lenzenweger et al., 2007).

1.3 Borderline Personality Disorder

The focus of the current research is part of Cluster B, Borderline Personality Disorder (BPD). The diagnosis of BPD has been used in services since the 1980's, although the term 'borderline' pre-dates this to the 1940's, where it arose from the belief that such patients were on the border between psychosis and neurosis (Hoch & Polatin, 1949). BPD is characterised by difficulties with affect regulation, impulsivity and insecure attachment, resulting in significant interpersonal difficulties and fear of abandonment (Livesley & Jang, 2005). It is also associated with a negative self-concept (Pinto, Grapentine, Francis, & Picariello, 1996); this can result in a person's belief they are unacceptable to others and require excessive reassurance and nurturing (Al-Alem & Omar, 2008). A significant feature of the Borderline presentation relates to the high prevalence of self-harming behaviour and

suicide attempts, with completed suicide rates over 50 times higher than in the general population (Soler et al., 2009).

Research on the trajectory of BPD has found that difficulties begin in adolescence and whilst short term outcome appears poor, long-term outcome is more positive as traits tend to “burn-out” over time, with approximately 70% making a ‘recovery’ from symptoms by middle age (Links & Heslegrave, 2000; Paris, Brown, & Nowlis, 1987; Paris, 2009; Stone, 1990; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2006). Before ‘burn-out’ occurs, BPD has a detrimental impact on a person’s quality of life, resulting in frequent access to professional services; as such it is associated with large costs to health care resources (Blum et al., 2008).

Although individuals with BPD have frequent contact with services, their presentation can make it difficult for therapists working with them; for example high rates of self-harm and suicide attempts can interfere with therapeutic goals (Al-Alem & Omar, 2008) and can also be mis-interpreted by the therapist as ‘manipulative’ behaviour (Commons-Treloar & Lewis, 2008). Interpersonal difficulties which are inherent in BPD can also create difficulties. It is common for a person with BPD to engage in ‘splitting’, an ego defence where good and bad objects are separated; this can result in rapid shifts from idealization (good person) to devaluation (bad person), which in therapy can impact on the therapeutic relationship (Millon, Grossman, Millon, Meagher, & Ramnath, 2004) and lead to dis-engagement from therapy (Chanen et al., 2009). In the past, these difficulties have led to the belief that BPD is ‘untreatable’, however this is no longer believed to be the case and research exploring therapeutic outcomes will be discussed in a later section.

The aetiology of BPD is still relatively unknown with sparse research exploring the role of causal factors. One twin study has been conducted which found a genetic link in the development of BPD (Torgersen et al., 2000); however there is not enough evidence to suggest specific heritability. There is more research exploring psychological factors with evidence suggesting traumatic early experiences such as abuse/neglect can increase the risk of developing BPD (Al-Alem & Omar, 2008; Paris, Zweig-Frank, & Guzder, 1994; Zanarini et al., 2006), with a correlation found between severity of abuse and severity of BPD traits (Silk, Lee, Hill, & Lohr, 1995). Research suggests that abuse impacts on a child's sense of reality as a result of feelings such as confusion, terror, anticipation, and unpredictability; this mood intensity, distorted sense of reality, and the confusing nature of relationships all are characteristic of BPD (Fall & Craig, 1998). However childhood experience is not thought to be a sufficient explanation, particularly when considering the population who have experienced adverse childhood events and not developed BPD. Therefore, although childhood abuse is a significant risk factor, it is "neither necessary nor sufficient for the development of borderline personality disorder" (Zanarini et al., 1997, p.1101).

More recently research has proposed a combined link between genetic vulnerability and adverse childhood events culminating in BPD traits (Al-Alem & Omar, 2008; Bateman, 2005; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). Lieb et al (2004) suggest the cause of BPD is complex, resulting from various interacting factors; they propose a neuro-behavioural model to explain these interactions (see Figure One below). The model suggests a culmination of genetic factors, such as a difficult temperament, and environmental factors, such as child abuse or neglect, can result in emotion dysregulation and impulsivity. This can lead to dysfunctional behaviours which can additionally serve to reinforce dysregulated behaviour and also impact on subsequent adverse events (e.g. harsh/critical parenting or risky situations resulting in abuse). However, as noted by the authors, research regarding

the aetiology of BPD is sparse and as such evidence regarding causal factors is inconclusive.

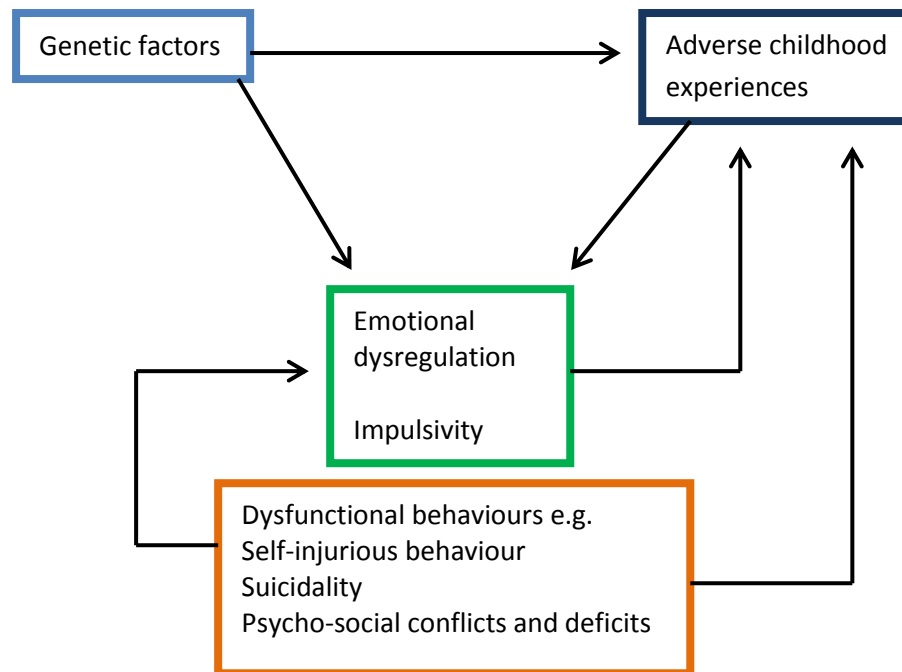


Figure One: Neuro-behavioural model of borderline personality disorder. (Source: Lieb et al, 2004)

1.4 BPD and Adolescents

As identified in the DSM-IV-TR, BPD is a pervasive disorder which can be diagnosed in adolescence following the same diagnostic criteria as for adults:

“personality disorder categories may be applied to children or adolescents in those relatively unusual instances in which the individual's particular maladaptive personality traits appear to be pervasive, persistent, and unlikely to be limited to a particular developmental stage or an episode of an Axis I disorder. To diagnose a personality disorder in an individual under 18

years of age, the features must have been present for at least one year” (APA, 2000, p. 687).

In addition, the presentation of BPD traits before the age of 18 is acknowledged by the APA (2000) with such early onset needed to satisfy the diagnostic criteria. However there has been much debate regarding whether BPD can be reliably diagnosed in adolescence or indeed whether it should be diagnosed in this population. Caution has been advocated due to the stigma attached to such a diagnosis and also due to the evolving nature of personality, with adolescence noted as a dynamic stage of development (Miller, Neft, & Golombeck, 2008). As discussed previously, there is overlap between difficulties arising from an adolescent stage of development and also arising from BPD. It has been suggested that ‘normal adolescence’ does not fit the unpredictable, persistence of BPD symptoms (Fall & Craig, 1998). However it is important to consider the overlap between adolescence and BPD difficulties as it raises questions relating to appropriate identification and intervention.

Over the past 10-15 years research exploring BPD in adolescence has increased with researchers exploring the validity of diagnosis in adolescence along with the advantages and disadvantages of this (Chanen & McCutcheon, 2008).

When comparing adolescents and adults, there is growing body of research to suggest that personality pathology creates similar difficulties across both populations (Chanen, Jovev, McCutcheon, Jackson, & McGorry, 2008; James, Berelowitz, & Vereker, 1996; Westen, Nakash, Thomas, & Bradley, 2006), with this evidence providing support for the validity of a BPD diagnosis in adolescence. For example longitudinal research has found maladaptive personality traits diagnosed in adulthood had their origins in childhood and could be reliably

identified and assessed at this time (Cohen et al., 2005; Skodol, Johnson, Cohen, Sneed, & Crawford, 2007). This is supported by Miller, Muehlenkamp, & Jacobson's (2008) literature review which found BPD traits were comparable across the age span indicating the identification and diagnosis of BPD in adolescence was reliable and valid. However they also noted for some adolescents the diagnosis was not stable with traits changing over time.

Some differences between an adult and adolescent BPD population have been identified. Research on BPD symptomology across the age span has found that when compared to adults, adolescents classified as suffering from BPD are more likely to have higher rates of suicide and self-harm, utilise health services less (Blum et al., 2008), demonstrate higher rates of aggressive, obsessive and dissociative behaviour and are also more likely to be involved in high risk sexualised behaviour (Segal-Trivitz et al., 2006). Whilst some differences in presentation have been noted between adults and adolescents the research suggests that overall BPD symptomology is very similar between the two age groups (Blum et al., 2008; Segal-Trivitz et al., 2006). Kreger (2010) suggests this similarity is due to the symptoms arising from skill deficits and difficulties regulating emotion; therefore highlighting the need for intervention to target the identified deficits.

Whilst the presentation is consistent for adult and adolescent populations, the discriminant validity of adolescent BPD has been found to be poor with adolescent BPD demonstrating a higher trait overlap with other personality disorders (Bondurant, Greenfield, & Tse, 2004). Separating BPD traits from other psychopathology constructs is therefore more difficult in adolescence suggesting diagnosis should be made with caution. In terms of early intervention, it may be more appropriate to consider adolescents 'at risk' of BPD and target interventions at an individual's difficulties arising from BPD traits.

As personality has been found to be less rigid in adolescence than adulthood, it has been proposed that early identification can result in more positive outcomes with intervention occurring before maladaptive personality characteristics become entrenched (Fall & Craig, 1998; Miller et al., 2008). Research by Zanarini et al., (2006) support this with findings that younger age of BPD diagnosis is associated with a more positive outcome at follow up. In addition it has been proposed that ignoring axis II conditions can lead to an exacerbation of difficulties with deterioration in mental health, academic functioning, social functioning, as well as an increase in self-harm, suicidality and substance abuse (Kernberg, Weiner, & Bardenstein, 2000; Miller, Neft et al., 2008).

Following a critical review of the evidence available for the putative diagnosis and treatment of BPD in adolescence, it can be concluded that whilst there is research to support this, it remains unclear when or how BPD should be identified and whether adolescent BPD traits remain stable over time. In addition with no agreed 'first choice' psychological intervention for adolescents with BPD (Chanen et al., 2008), it remains unclear what intervention should be offered. Available literature on the effectiveness of BPD interventions for adults and adolescents will be reviewed in the next section.

1.5 Psychological Interventions for BPD

There is little research assessing psychological interventions for BPD with limited evidence demonstrating 'what works', in particular there is an acknowledged lack of research regarding therapeutic interventions for adolescents (National Institute for Health and Clinical Excellence, 2009).

A Cochrane review (Blinks et al., 2009) examined the research evidence for the effects of psychological interventions with BPD. The review involved a systematic search of twenty-six general and specialist databases for studies involving randomised controlled trials (RCT) of psychological interventions for people diagnosed with BPD. Psychological interventions included behavioural, cognitive-behavioural, psychodynamic and psychoanalytic approaches.

Seven studies involving 262 people were identified (a table containing relevant details for each study can be found in Appendix One). Overall, evidence from these studies suggests psychological intervention is more effective than medical intervention, with DBT and psychoanalytic interventions demonstrating some effectiveness. However it is difficult to draw conclusion from the RCT findings due to the small number of studies reviewed and the bias on studies using a DBT approach for BPD. In addition some methodological difficulties were noted with the studies reviewed such as small sample sizes, differences between conditions (e.g. differing duration, amount and type of therapy received) and differences between therapists (training, age, gender etc); therefore suggesting the findings should be interpreted with caution. The authors of the Cochrane review also noted difficulties in reaching a conclusion based on the studies reviewed, stating on p.2:

“This review suggests that some of the problems frequently encountered by people with borderline personality disorder may be amenable to talking/behavioural treatments but all therapies remain experimental and the studies are too few and small to inspire full confidence in their results. These findings require replication in larger ‘real-world’ studies.”

In addition, this body of research is confounded by the difficulties noted previously relating to the heterogeneity of the BPD population. As the individuals and therefore the groups could be very different to one another it will be difficult to determine whether the results are related to the intervention option or the group differences. It is therefore important to interpret any RCT evidence in this area with such difficulties in mind. Although there are inherent difficulties with the available RCT evidence, interventions for people with BPD are currently being evaluated through the use of RCT's and as such must be considered.

To further examine RCT evidence for BPD interventions, the researcher conducted a literature search to identify RCT studies between 2008 and 2012. The search string of 'Randomised controlled trial AND borderline personality' was used in seven scientific databases (PsycINFO, PsycARTICLES, Medline, CINAHL Plus, Global Health, AMED and Web of Science). The search found three RCT trials:

Bos, van Wel, Appelo, & Verbraak (2011) explored the effectiveness Systems Training for Emotional Predictability and Problem Solving (STEPPS), a group treatment for BPD. Eighty-four participants were randomly allocated to STEPPS with individual therapy and 84 participants were allocated to TAU group; all participants showed clinical features of BPD but may not have had a DSM-IV-TR diagnosis. Results found greater improvement across psychopathology measures for the STEPPS condition. The presence of a diagnosis was not related to treatment effectiveness suggesting this intervention could be beneficial for clinical samples presenting with BPD traits, but who do not meet the full diagnostic criteria.

The second RCT identified explored transference focussed psychotherapy versus treatment by community psychotherapists (Doering et al., 2010). One hundred and four females with

BPD were randomly allocated to one of the year-long treatment groups. Both groups significantly improved in scores on depression and anxiety. Transference focussed psychotherapy was found to be superior on outcome measures of general psychopathology, borderline symptomatology, suicide rates and drop-out rates. However no group resulted in a reduction in self-harm behaviour which is a significant difficulty related to BPD.

The third RCT by Soler et al. (2009) compared DBT skills training to standard group therapy for participants diagnosed with BPD (n=60). The results found DBT skills training had a lower drop-out rate and demonstrated superiority to standard group therapy across a range of general psychopathology measures. However, similar to Doering et al., (2010) neither group had a significant impact on characteristic borderline behaviours such as self-harm and suicidality.

In addition, three reviews which examined RCT evidence up to 2008/2009 were found (Cailhol et al., 2011; Dixon-Gordon, Turner, & Chapman, 2011; Hadjipavlou & Ogrodniczuk, 2010); all had similar findings to the Cochrane review and suggested the need for further research. Finally, a meta-analysis by Kliem, Kröger, & Kosfelder (2010) was found which explored RCT and non RCT evidence for DBT. Sixteen studies were identified (8 RCT and 8 non-RCT); the results found evidence that DBT was efficacious compared to TAU and demonstrated effectiveness in routine clinical practice. However when compared to other BPD specific therapies such as schema-focussed or transference focussed therapy the evidence for efficacy of DBT was smaller.

The findings from the above literature suggests that psychological intervention can be helpful in targeting some of the difficulties associated with BPD, and can also be helpful for use with

individuals in routine clinical practice who do not meet full diagnostic criteria. However there is not enough evidence to determine which intervention is the most efficacious. In particular there are concerns with some interventions not resulting in improvement on significant BPD behaviours such as self-harm or suicide attempts. Further research in this area is needed to explore how therapeutic interventions can be improved and to help identify which elements of therapy are found to be most helpful to individuals with BPD. Qualitative research would be an appropriate method of gathering such data as it would allow individuals with BPD to discuss and evaluate their experience of receiving therapy. Qualitative research is therefore discussed in a later section.

The researcher also conducted a search to identify RCT studies investigating psychological interventions for BPD, specifically conducted with adolescents. The search string 'Borderline Personality AND Randomised Controlled Trial AND adol*' was used, with no date limit, in the same scientific databases described previously. One RCT was found which evaluated Cognitive Analytic Therapy (CAT) versus manualised Good Clinical Care (GCC) (Chanen et al., 2008), with 84 adolescents allocated to one of these treatment groups. The results did not find a significant difference between the groups; both interventions resulted in significant improvements in symptomatology, although the CAT group demonstrated quicker improvement.

In addition an evidence summary for treating BPD in adolescence was published in 2009 by Headspace, a national youth mental health foundation (Scanlan, Purcell, Chanen, McGorry, & Yung, 2009). The summary looked at available RCT and non-RCT evidence for adolescents and adults with BPD and concluded there was a 'knowledge gap' relating to psychological treatment for adolescents. It is clear from this summary that available research

for adult and adolescent interventions is insufficient to determine which therapeutic approach is most effective.

After critically reviewing the available literature, it can be concluded that the evidence for psychological interventions in the treatment BPD is sparse, particularly for adolescents. Whilst the available literature suggests DBT has the most empirical support, and as such has been identified by the government as the recommended intervention for adults (National Institute for Health and Clinical Excellence, 2009), further research is needed in this area.

1.6 Dialectical Behaviour Therapy

As noted previously Dialectical Behaviour Therapy (DBT) is the recommended psychological intervention for adults with BPD, with this adult recommendation also deemed applicable to adolescents (National Institute for Health and Clinical Excellence, 2009). As a result of these NICE guidelines on BPD, DBT is the treatment of choice in the NHS as it has the largest evidence base supporting its effectiveness. However the evidence base is limited, particularly for adolescents, and as such this study aims to evaluate the use of DBT in NHS practice. DBT is therefore outlined below with a particular focus on its use in NHS clinical practice.

DBT was adapted from Cognitive Behaviour Therapy (CBT) and was initially developed by Marsha Linehan as an intervention for BPD and associated high rates of self-harm and suicidality (Linehan, 1993). The DBT model is based on bio-social theory which acknowledges the two levels influencing the development and maintenance of BPD behaviours – intrapersonal biology and the interpersonal social environment (Calvert, 2012). This theoretical stance is in concordance with previously discussed literature which suggests

personality disorder develops as a result of an interaction between genetic vulnerability (bio) and adverse life events (social). Linehan (1993) describes an 'invalidating environment' whereby the child is unable to develop skills in regulating or expressing emotions as attempts to do so can be met with negative consequences. This can result in an increased sensitivity and reactivity to emotions and also difficulties in coping with the associated arousal, with the use of self-harm employed as a coping strategy. Adolescents are most at risk from suicide and self-harm behaviours with a peak in this behaviour between the ages of 16-18 (Miller, Rathus, & Linehan, 2007). In addition approximately 70% of adolescents with a personality disorder engage in self-harm behaviour (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006).

A significant concept of DBT is that the presenting BPD behaviours are viewed as arising from difficulties with affect regulation and a lack of behavioural skills impacting on coping strategies. DBT aims to address these skill deficits in a multi-modal treatment utilising a hierarchical approach to address difficulties. The DBT model comprises five stages of recovery to target BPD and other co-morbid difficulties (Calvert, 2012; Dimeff & Koerner, 2007; Miller, Rathus, & Linehan, 2007; Swales & Heard, 2009). Each stage is described briefly below:

Pre-intervention – At this initial stage patients are orientated to DBT in one-one therapy, for approximately three-four sessions. The aim is to develop a collaborative understanding of the presenting difficulties and link these to the goals and targets of therapy. Commitment to therapy is also explored at this stage to help increase motivation and reduce drop-out rates.

Stage One – This stage aims to enhance emotional and behavioural stability by reducing risk behaviour, increasing quality of life behaviours and increasing behavioural skills; one-to-one therapy, a skills group and telephone coaching are utilised. This stage is particularly relevant for BPD difficulties and as such is the stage most utilised in NHS services. Some patients end treatment after this stage whilst others may require additional stages to enhance their recovery; they may either move on to another stage or repeat stage one. Components of stage one will be described in additional detail.

Stage Two – This stage is particularly relevant for patients with a history of trauma. In one-to-one therapy Post Traumatic Stress Disorder (PTSD) symptoms are targeted with the aim to help patients emotionally process their past. Skills from stage one are utilised.

Stage Three – In this stage difficulties are targeted which are of lower severity than those arising in stage one or stage two. These may include marital, education, employment, housing problems etc. Through one-to-one therapy and work with relevant organisations the aim is to increase happiness and work towards achieving a 'life worth living'. It is unlikely this stage would be addressed within NHS services.

Stage Four – This stage also focusses on achieving a 'life worth living' for patients who continue to experience difficulties in this area. Goals towards life satisfaction could be addressed through one-to-one therapy, spiritual or religious practices. It is unlikely this stage would be addressed within NHS services.

The DBT model for stage one outlines a hierarchy of goals:

1 - *Life threatening behaviours*; these are targeted first as they are classed as the most dangerous/harmful behaviours which could result in physical harm. Behaviours include self-harm, suicide attempts, substance misuse, eating disorders, aggression/violence directed at others. The function of these behaviours are identified and alternative ways of coping explored and practiced.

2 - *Therapy interfering behaviours*; these can include both therapist and patient behaviours e.g. the therapist may feel angry as the patient has been missing appointments or the therapist may avoid topics as they make the patient upset/angry. These types of behaviours can lead to invalidation, lack of acceptance and prevent change.

3 - *Quality of life interfering behaviours*; these refer to co-morbid difficulties which impact on the person's well-being and functioning. Although the person may have developed more effective coping strategies, additional difficulties could continue to interfere with their quality of life. Targeting co-morbid difficulties is thought to be more effective once some behavioural stability has been achieved.

4 - *Learning of behavioural skills*; the above goals can be achieved through the development of skills to help cope with difficult situations and emotions. Skill development and acquisition occurs throughout DBT.

DBT utilises a multi-modal approach to achieve its goals. Therapy lasts for approximately one year and involves a combination of individual therapy, a skills group, telephone coaching and staff consultation. Each aspect is described in further detail below.

1.61 Individual Therapy:

This occurs weekly for approximately one hour. A significant element of this is introducing the person to the concept of dialectics; in particular the dialectic between acceptance and change is explored. In addition the person's individual dialectics are explored. Calvert (2012) explains the dialectic principles in DBT in figure two below.

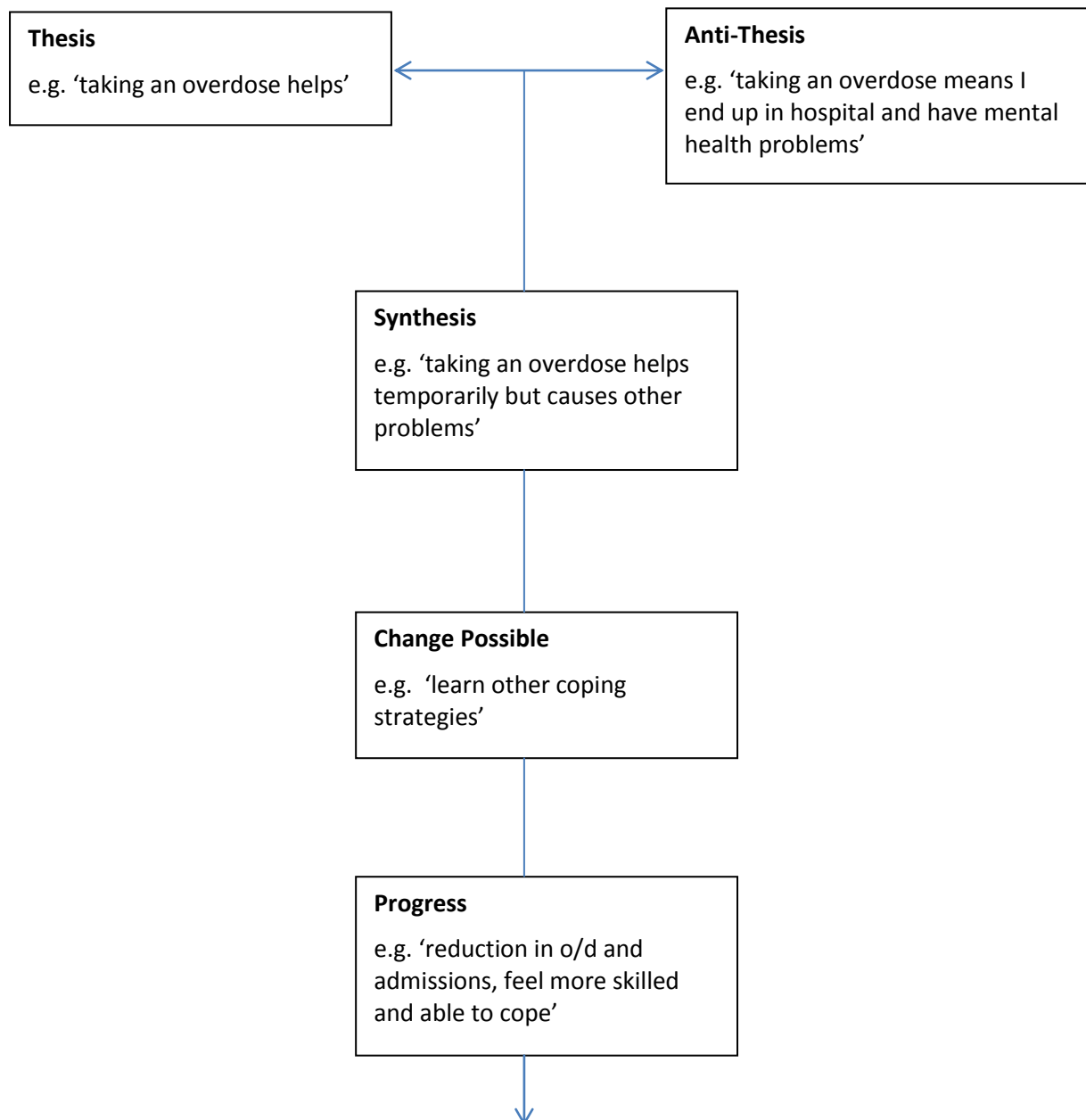


Figure Two: Principles of Dialectics in Dialectical Behaviour Therapy. (Source: Calvert, 2012)

Individual sessions also explore 'problem' situations and behaviours with the use of chain analysis and the identification of antecedents, behaviours, consequences and emotional response throughout. The purpose of this is to facilitate the identification and understanding of difficulties and identify solutions. An important element of the solution identification involves reviewing the skills developed in the group and exploring alternative coping strategies.

1.62 Skills Group:

A significant goal of DBT is to reduce skill deficits and increase effective coping strategies. Skills are introduced and explored in group sessions which last approximately 2½ hours and cover four different modules:

Core Mindfulness: This module introduces mindfulness as a skill to facilitate acceptance. Linehan (1993) also incorporates the concepts of 'reasonable mind', 'emotional mind' and 'wise mind'. Reasonable mind is a state where emotion is not acknowledged, instead logical thinking is predominant in making decisions. Emotional mind is a state where decisions are based predominantly on emotions. Wise mind is a state which acknowledges both emotions and logic to help make decisions towards a 'life worth living'; wise mind is classed as a synthesis between reasonable and emotional mind.

Distress Tolerance: This module facilitates the identification of 'overwhelming' emotions which are likely to have resulted in poor coping strategies such as substance abuse or self-harm. Alternative skills are therefore explored such as distraction or self-soothing to help cope with distress.

Emotion Regulation: This module aims to develop understanding and identification of emotions which can become 'confusing' 'out of control' or 'overwhelming'. In addition problem solving and alternative behavioural responses to emotions are discussed.

Interpersonal Effectiveness: This module aims to develop skills in social situations to ensure the needs of everyone involved are considered in a respectful and thoughtful manner.

1.63 Telephone Coaching:

This element involves facilitators being available in between group and individual sessions to offer skill coaching, as opposed to therapy or therapeutic support. The aim of the phone coaching is to help generalise therapy to every-day life, develop skill use and reduce crises. This phone call allows the facilitator and participant to consider the situation, choose an appropriate skill and consider how to apply this in an effective manner. The participant is encouraged to call for skill coaching before they reach a crisis or become suicidal.

1.64 Staff Consultation:

This is linked to supervision, however for the purposes of DBT the format is structured and aims to problem solve any difficulties and maintain facilitator motivation and adherence to the DBT model. It also aims to develop facilitator skills and identify any potential facilitator therapy interfering behaviours. It is recommended consultation occurs once a week for approximately two hours.

DBT has also been adapted for use with adolescents presenting with BPD traits, whilst it is still a multi-modal treatment with hierarchical goals, as described above, there are some

differences. It has been designed to be delivered over a shorter time span (approximately 6 months as opposed to a year), utilises a smaller number of skills, uses language and handouts appropriate for adolescents and places greater emphasis on family involvement with an additional module 'walking the middle path'.

1.65 Walking the Middle Path:

This module was developed to target difficulties arising specifically with adolescents and their families. The module focusses on the dialectic of change versus acceptance and also explores difficult parent-adolescent interactions. Whilst it is helpful for parents or care-givers to be involved throughout DBT and in particular with this module, the authors recognise this is not always possible or appropriate (Miller, Rathus, & Linehan, 2007).

As noted previously, although research on the effectiveness of DBT is limited, it has been found to be effective at reducing suicide and self-harm rates (Verheul et al., 2003), improving affect instability, irritability, depression and anxiety (Soler et al., 2009) and reducing service utilisation (Brassington & Krawitz, 2006). Qualitative accounts, although small in number, also support the effectiveness of DBT with participants reporting a reduction in self harm, having a positive experience with the group and feeling their lives had changed for the better (Hodgetts, Wright, & Gough, 2007; Perseus, Öjehagen, Ekdahl, Åsberg, & Samuelsson, 2003). However research has focussed largely on an adult population, and although DBT is used with an adolescent population, little research has been conducted to support this.

1.7 Therapeutic Groups

Whilst there is no evidence to suggest group interventions are superior to individual interventions (Lambert & Bergin, 1994), therapeutic groups appear to be an important aspect

of interventions for people with BPD; indeed all the BPD interventions reviewed involved groups. The group element could be considered important for BPD interventions due to the inherent difficulties with interpersonal relationships found with this client group. Yalom's key research in the area of therapeutic groups discusses 'therapeutic factors' which relate to the beneficial effects of group processes on the individual, for example a sense of belonging or feeling valued (acceptance), discovering they are not alone with their difficulties (universality), relief from discussing intense emotions/feelings (catharsis) and receiving useful information/advice (guidance) (Yalom, 1975, 1985, 2005). The importance of group processes on the outcome of therapy has also been noted with research suggesting that group processes and therapeutic alliance or 'common factors', account for a larger percentage of therapeutic change than specific therapy techniques (Asay & Lambert, 1999; Wampold, 2001).

Qualitative research can help to explore the effectiveness of therapy, as consideration can be given to both common factors and specific therapy factors when discussing and evaluating therapeutic change (Macran, Ross, Hardy, & Shapiro, 1999). Such research has focussed on the process of therapy and explored patient accounts of their therapeutic experience, with the aim to develop understanding of the positive and negative processes impacting on therapeutic benefit and also identify changes needed to increase effectiveness and perceived helpfulness of the intervention (e.g. Griffiths, Camic, & Hutton, 2009; Laberg, Törnkvist, & Andersson, 2001; MacDonald, Sinason, & Hollins, 2003; Newton, Larkin, Melhuish, & Wykes, 2007). Themes identified in this literature relate to group (e.g. acceptance, trust, universality), therapist (e.g. confidence, helpfulness, support), treatment (e.g. duration, individual sessions, skill development) and interpersonal factors (e.g. social interaction, expectations). It will be interesting to note whether such factors are also identified within the current research.

There is limited qualitative research specifically exploring participant experiences of DBT interventions with only two studies conducted in this area to date, both with an adult sample:

Firstly, Persius et al (2003) explored both participant and therapist perceptions of DBT. Ten female patients who had participated in the DBT programme were interviewed along with four DBT therapists (2 male, 2 female); interviews were subsequently analysed using content analysis. The findings suggested that both patient and therapist felt DBT was 'life-saving', with skills acquired to help manage and control self-harm behaviours and urges. The importance of rapport and a good therapeutic relationship was also noted to contribute to a successful outcome, with patients attributing a good relationship to therapist characteristics whilst the therapists attributed this to the DBT model. In addition, the support received from the group was found to be a positive contributing factor to change. Overall the findings suggest that therapist and patient perceptions of DBT therapy are unanimously positive. However it is important to note that participants who decided not to continue with DBT were not included, nor were individuals at an earlier stage of therapy. Inclusion of these individuals may have resulted in a more varied and potentially less positive perception of DBT.

Secondly, Hodgetts et al, (2007) explored participant experience of DBT; five participants (2 male, 3 female) took part in the interviews which were analysed using Interpretative Phenomenological Analysis (IPA). Findings suggest, similar to Persius et al, (2003), that the therapeutic relationship and the group sessions were important factors, particularly in terms of their perceived support. However in contrast to the previous findings, not all participants found DBT to be a completely positive experience, with participants discussing difficulties with different components of the therapy (individual sessions versus group sessions), difficulties with anxiety, feeling DBT could be too 'rigid' and may not always apply to the

individual and a desire to discuss past traumatic events. It could be the differing findings were due to features of the participants who were included, as Hodgetts et al, (2007) interviewed individuals at different stages of the DBT programme and also interviewed participants who decided not to continue with therapy. However the interviewer in Hodegetts et al's (2007) study also formed part of the DBT team involved in delivering the therapy received; this may have led to a bias in participant response and also in the research interpretations made.

Overall the qualitative literature suggests both common and specific factors are important to perceived benefit from therapy, with the evaluation of DBT therapy also considering these factors. Whilst there was acknowledgement that DBT could be a positive and helpful experience, this was not always found; whilst it is unlikely that any therapeutic intervention would unanimously be viewed as positive, more research would be helpful to explore these mixed DBT findings further. In particular qualitative information is yet to be sought from adolescents who have engaged in the DBT programme.

1.8 Aims, Objectives and Rationale for the Current Study

The review of the literature indicates that people with a diagnosis of BPD suffer from significant distress and difficulties in functioning. These difficulties have an onset in adolescence and services are currently offering therapeutic interventions at this age. In particular DBT (stage one) is offered through the NHS as it has the largest evidence base supporting its use. However, overall this evidence base is sparse, particularly with an adolescent population. The current ways of evaluating the effectiveness of therapies such as DBT is through an RCT; although as discussed, for a BPD population this method is inherently flawed due to the heterogeneity of the population.

It is also important to consider the participant's point of view when evaluating therapeutic effectiveness; however qualitative evaluation of DBT is extremely limited with no research of this type conducted with adolescents to date. The current study is therefore exploratory in nature and will expand the research in this area by asking adolescents to evaluate their experience of receiving DBT. This qualitative evaluation aims to help identify the factors found most and least helpful in therapy; adding to the evidence base identifying 'what works' for BPD in adolescence.

The objectives of the study are to:

1. Investigate adolescent experiences of receiving DBT, reflecting on the therapy process.
2. Consider the impact therapy may have had on participant's lives (and the lives of their family / friends); changes from past to present and hopes for the future.
3. Develop an understanding of the perceived role of the therapist in this process.
4. Compare findings with those from previous research in this area conducted with adults.

CHAPTER TWO: METHOD

This chapter discusses the rationale for the analysis chosen, along with the epistemological and methodological components of the study. In addition this chapter presents a detailed account of the procedure and process of data analysis.

2.1 Rationale for Thematic Analysis

When conducting research it is important to discuss the rationale for choosing a particular method of analysis. As discussed previously a qualitative approach was felt to be appropriate for the current study due to the inherent difficulties conducting randomised controlled trials with such a heterogeneous population. Different types of qualitative approaches were considered such as Grounded Theory, Narrative Analysis and Interpretative Phenomenological Analysis, to determine which approach best fit with the aims of the current study.

Grounded Theory is commonly used to develop a theory based upon the meanings derived from the data; to this end the data are categorised and consideration given to the relationship between the different categories to aid theoretical understanding (Willig, 2001). However as the current study is exploratory in nature, Grounded Theory would not be an appropriate choice. In contrast Narrative Analysis would fit the aims of the research as it is used to explore a subjective experience or 'story' in order to further understand the area being investigated. However Narrative Analysis is often used to explore an individual's experience, and would therefore not fit the current study which explores a number of participant experiences. Interpretative Phenomenological Analysis (IPA) is also used to explore an individual's experience and aims to gain insight into how people make sense of their experiences (Smith, Flowers & Larkin, 2009). In contrast to Narrative Analysis, IPA

develops a summary of themes across participants; as such IPA was deemed to be an appropriate fit for the current study and was initially considered as the method of analysis. However after further consideration it was felt the heterogeneity within a BPD population would create difficulties with an IPA approach which requires the sample to be as homogeneous as possible.

After the above qualitative methods were explored and ruled out, consideration was given to Thematic Analysis. Thematic Analysis is used to identify and interpret themes across a data set and has a flexible approach compatible with a heterogeneous sample (Braun & Clarke, 2006). As such Thematic Analysis was felt to fit the aims of the current study and was felt to be an appropriate choice for the research population.

2.2 Epistemological Position

When conducting a Thematic Analysis, or indeed any qualitative research, it is important for the researcher to be explicit in stating their epistemological position, as the assumptions held impact on the analysis and conclusions drawn from the data (Boyatzis, 1998; Willig, 2001; Braun & Clarke, 2006). The epistemological position refers to the method of analysis and any theory underpinning this; it therefore guides the analysis of the data and the meanings drawn from the data (Braun & Clarke, 2006). Thematic Analysis adopts a flexible theoretical approach and as such can be conducted from either a realist or constructionist position.

A realist epistemological position focuses on individual motivations and experiences, with interpretations made based on these individual accounts. In contrast a constructionist position does not focus on individual accounts; rather it considers the social and cultural

contexts underpinning an individual's experience. The epistemological position of the current research fitted into a realist framework as it aimed to explore individual's experience of DBT.

As well as deciding on the epistemological position, other key decisions needed to be made about the method and process of thematic analysis. These are described in further detail below and are namely; analysing the entire data set for themes versus a detailed account of one aspect of the data, an inductive versus a theoretical approach and identifying semantic versus latent themes.

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The current research utilised Thematic Analysis to provide a rich description of the entire data set as opposed to focussing on one aspect of the data. Exploring the entire data set was felt to be important due to the exploratory nature of the research. Indeed Braun & Clarke (2006) suggest that providing an overall account of the data is useful when researching an under-explored area or when interviewing participants whose views on a topic are not known; as was the case for the current study. Based on this decision, it was felt an inductive approach would be more appropriate than a theoretical approach. A theoretical approach would focus on relevant theory and code the data based on this, resulting in a detailed account of one aspect of the data. In contrast an inductive approach codes without such preconceptions, with themes generated having strong links to the data set.

A decision also needed to be made in relation to whether themes were identified at a semantic or latent level. A semantic level of analysis was felt to be appropriate for the current study as it focuses on what the participant has said with interpretations made based on patterns within the data. In contrast latent themes are analysed and interpreted based on underlying theory and links to a constructionist approach.

The current study therefore employed Thematic Analysis within a realist perspective to explore participant's experience of DBT. An inductive approach at a semantic level generated themes which were strongly linked to the data set and enabled a rich description of participant's DBT experience.

2.3 Design

The study employed a qualitative approach in order to explore and construct themes across the data set. A semi-structured interview schedule (Appendix Two) was utilised to aid in the collection of rich data covering a number of areas related to the experience of engaging in a DBT programme.

2.4 Inclusion and Exclusion Criteria

All adolescents who took part in the Young People's Mental Health Service pilot DBT programme were invited to take part. To reduce the potential for bias, participants at different stages of the programme and participants who had chosen not to continue with DBT were also approached; as such there were no exclusion criteria.

2.5 Participants

Eight people agreed to be contacted by the researcher and from these five consented to interview. Demographics of the five participants can be seen in Table One below. All participants were white, British, adolescent females who had taken part in DBT.

	Gender	Age	Ethnicity	DBT Status	Current Service Status
1	Female	17	White British	Completed 0.5 of a module before opting out.	Receiving one-one support from a psychologist
2	Female	17	White British	Completed all 5 modules.	Currently admitted on psychiatric unit.
3	Female	19	White British	Completed all 5 modules.	Receiving one-one support from a psychologist
4	Female	18	White British	Completed 3 modules before opting out.	No longer in contact with the Young People's Mental Health Service.
5	Female	18	White British	Completed 3 modules, before opting out.	Receiving one-one support from a psychologist

Table One: Participant Demographics

2.6 DBT Intervention

The DBT package received by the participants conformed to the DBT model for stage one as outlined previously. In accordance to the DBT model the intervention was adapted for adolescents and included the module 'walking the middle line'. The two clinicians conducting

the therapy had received standardised DBT training. Both of the clinicians had a significant amount of experience working with adolescents with BPD; a clinical nurse specialist with over fifteen years experience working with adolescents and a clinical psychologist with over eight years experience working with adolescents. The two clinicians received consultation and supervision from other DBT clinicians within their trust to meet the requirements of the DBT model.

2.7 Procedure

2.71 Ethics

A research proposal was submitted to the Department of Clinical Psychology research committee and approval was received in July 2011. Following this ethical approval for the study was sought and approval obtained from the Local Research Ethics Committee. In addition NHS Research and Development governance approval was gained from the relevant NHS Foundation Trust (see Appendix Three for all approval correspondence).

2.72 Recruitment

All participants were recruited from an NHS pilot DBT programme which began in March 2011. Following referral to the Young People's Mental Health Service a standard assessment procedure was followed to identify the needs of the young person; with the case discussed at a Multi Disciplinary Team meeting to agree on intervention options. Identified adolescents were deemed suitable for DBT if they had traits associated with the DSM criteria for borderline personality disorder, including a history of emotion dysregulation, use of self-harm as a method of coping with distress and a history of unstable interpersonal relationships.

All attendees at the DBT programme were initially approached by one of the NHS clinicians to obtain consent to be contacted by the researcher via telephone; however all individuals were advised that being contacted did not mean they were consenting to the study nor were they were obligated to consent to contact. All individuals who agreed to contact were sent an information sheet (Appendix Four) and consent form (Appendix Five). Participants were given a minimum of 7 days to receive this information and consider participation before they were contacted by the researcher. During the telephone contact participants were provided with information regarding the study, given the opportunity to ask any questions about the research and if they were in agreement to take part in the research a meeting was arranged at a convenient date, time and location.

2.73 Interview Schedule

A semi structured interview schedule was developed to facilitate exploration of the research area. The use of a semi structured interview enabled consistent coverage of topic areas across participant whilst allowing the flexibility for detailed data to be gathered.

Due to the limited research in this area, the schedule was developed to allow a broad evaluation of DBT, with consideration given to before, during and after therapy as well as thoughts about the future. The schedule invited participants to discuss and evaluate their experience of this package of therapy and discuss salient factors they found to be most or least helpful. Participants were also given the opportunity at the end of the interview to discuss or expand on areas they felt had not been covered. In line with the flexible approach of a semi structured interview, additional questions, which did not form part of the schedule, were asked as appropriate. These additional exploratory questions facilitated the gathering of rich, detailed data.

The interview schedule was piloted with a colleague and the questions refined following this. Prompts were included to aid with follow up questions and also the flow of the conversation during the interview. The interview schedule consisted of 26 questions relating to participants experience and evaluation of receiving DBT.

2.74 Interview Process

Interviews were initially planned to take place at the Young People's Mental Health Team where the DBT sessions took place. However this was not a convenient location for the participants and after consideration of risk factors, the majority of interviews took place at the participant's home address, with one interview taking place on an inpatient unit.

Participants were asked for an hour of their time to discuss the participant information sheet and if they were still interested, sign the consent form and conduct the interview. Confidentiality was discussed at the outset with participants informed of the confidential nature of the research and the anonymity involved. However they were advised of the limits to this if they disclosed information indicating they or another person were at risk of harm. In this instance concerns would be discussed with the participant and, as per the procedures in place, discussed with the research collaborator from the recruitment site for advice; however this did not occur during any of the interviews.

Participants were given the opportunity to ask any questions relating to the information sheet and its content was reviewed with particular focus given to the purpose for the research, contact details and the right to withdraw. Next, the consent form was completed with emphasis placed on the need for the session to be audio recorded. Following this the

interviews began with the interview schedule used as a guide for discussion throughout. Interviews lasted between 30 minutes to 1 hour, with an average length of 40 minutes.

Following completion of the interview participants, the recording was turned off and participants were invited to ask any questions and time was provided to debrief. At this time participants level of distress was explored. Whilst procedures were in place for the participant to speak to someone if needed, this was not necessary following any of the interviews. However participants were reminded of contact details contained within the participant information sheet. Finally participants were asked if they would be interested in meeting with the researcher to engage in a feedback session once the data was analysed, and in addition if they would be interested in receiving generic feedback relating to the research once it was completed.

2.8 Data Analysis

The stages of thematic analysis, as outlined by Braun & Clarke (2006), were used to analyse the data. Each stage will be discussed in turn.

2.81 Familiarisation with the Data

Transcription is thought to be an important element of data familiarisation, however due to time constraints it was not possible for the researcher to transcribe the interviews. Instead the verbatim transcriptions were completed by a staff member from the University of Liverpool. Once each transcription was received it was checked for accuracy with the researcher reading the transcript whilst simultaneously listening to the recording; this method also helped the researcher to immerse themselves in the transcript. In addition a transcript

was read a number of times to facilitate data familiarisation and initial ideas about the content were noted on paper. This process was completed for all five interviews and was an important step in the search for repeated patterns and themes in the data.

2.82 Coding the Data

Codes are used to help organise and provide meaning to the large amount of data generated and this is felt to be an important part of the overall analysis (Braun & Clarke, 2006). At this stage, Braun & Clarke (2006) recommend being inclusive and coding for as many potential themes as possible, with the option of coding extracts numerous times if needed.

After the interviews were listened to and read a number of times, columns were added to the transcripts to help facilitate the coding of the data; one column was used for initial codes and another column for higher order codes. Each transcript was considered line by line or in small paragraphs and initial codes compiled. Initial codes were generated at a semantic level, directly from the transcript data, and often comprised of a summary of the extract. Initial codes were compiled across the entire data set with higher order codes generated from these initial codes.

The higher order codes remained at a semantic level, however moved beyond descriptives to a more interpretative conceptualisation of the data. An example of initial and higher order coding can be seen in table two below, where a participant is discussing how they noticed positive change in another group member.

<p>..”when we do the homework like some people like use the same examples but I noticed this one person like got closer to someone, like they are not really arguing that much anymore cause like she uses the skills....I think people have got better... it feels good cause I know like that if it works for them then it can work for me”.. (I2, 8, 245)</p>	<p>Noticing change in others from using skills</p> <p>Others’ positive change leads to hope for self</p>	<p>1. Change in other group members</p> <p>2. Installation of hope</p> <p>3. Interpersonal learning</p>
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Table Two: Data extract with initial and higher order codes

A large amount of higher order codes resulted from this process, approximately 500 codes. Due to the large amount of data each code was referenced (interview number, page number and starting line number) to aid in identification of its corresponding data extract; for example the extract in table two had a reference of I2, 8, 245. Each higher order code was then printed out in preparation for the next stage.

2.83 Searching for Themes

At this stage the higher order codes generated from the entire data set were printed on to individual sheets of paper and were used to search for themes. The codes were spread out over a large surface and collated into clusters based on commonalities and patterns. Relationships within and across the clusters were considered and from this process the codes were initially clustered into 26 themes (Appendix Six).

To further develop these clustered themes, consideration was given to the relationship between the themes along with the level of themes (Braun & Clarke, 2006). This resulted in themes being combined and also aided in the identification of potential over-arching (main) and sub themes. Significant themes were becoming apparent at this stage and an initial thematic map presenting six main themes (Appendix Seven) was produced to represent a coherent fit across the entire data set. Figure three below provides an example of one of the main themes from the initial thematic map.

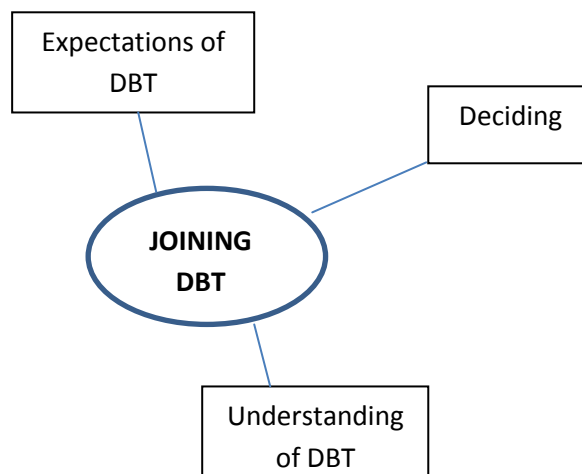


Figure Three: Extract from the initial thematic map, showing one main theme and three sub-themes

2.84 Reviewing Themes

After the initial thematic map was produced, the themes were reviewed and refined to ensure they represented a coherent fit across the data set. As recommended by Braun & Clarke (2006) consideration was given to the homogeneity of the data within a theme and also the heterogeneity and identifiable differences between themes. In order to produce a final thematic map which accurately represented the entire data, themes were reviewed and

revised at two levels, as described by Braun & Clarke (2006). This resulted in themes being split and merged to ensure they formed a coherent fit with the data set.

Firstly the themes were reviewed at the level of coded data extracts. This involved re-reading all of the coded extracts for each theme to determine whether they formed a coherent fit. On occasion, not all coded extracts fit within a theme and at this time the theme was refined. Consideration was given to whether the codes could fit under a different theme, whether they could create an additional theme or if there were not enough data to support them, whether they should be discarded. Level two involved a similar process and at this stage the validity of each individual theme was considered along with whether the thematic map presented an accurate representation of the entire data set. This involved re-reading each transcript, checking the themes fit with the data and also checking for any additional coding that may have been missed. It was important to refine the thematic map until it was felt to be an accurate representation of the data set; this refinement was on-going throughout the analysis.

2.85 Defining and Naming Themes

After the initial thematic map was produced consideration was given to defining each theme to ensure it accurately conveyed the data it represented. Braun and Clarke (2006) suggest that themes should capture the 'essence' of what aspect of the data they describe. Once each theme was defined and named the final thematic map was completed (Appendix Eight). Braun & Clarke (2006) suggest that, following this, attention should be given to writing a detailed analysis of each of the individual themes and their relationship to each other. This analysis can be found in the next chapter.

2.9 Validation of the Analysis

The analysis was validated at numerous time points. Firstly a number of transcripts containing initial codes were reviewed by the research supervisor, followed by all the transcripts containing both initial and higher order codes. The purpose of this was to ensure the codes provided an accurate representation of data. Secondly the initial themes and initial thematic map were reviewed, to again check the researcher was remaining true to the data and providing an accurate conceptualisation of the participants' evaluation of their DBT experience. It was also planned for participants to review the themes to check they were a true representation of their experience of DBT. Participants were asked prior to the interview if they would be interested in meeting with the researcher for this; however no participants agreed to take part.

CHAPTER THREE: RESULTS

This chapter discusses the findings from the thematic analysis of the entire data set. An overview of the main themes is presented followed by discussion of each main theme and sub-theme. Direct quotes from the data are used to help illustrate the findings.

3.1 Overview of the Main Themes

Analysis of the five interviews, as described in Chapter Two above, resulted in the identification of four main themes relevant to the research. The aim of the research was to explore adolescents' evaluation of their DBT experience in order to help develop an understanding of what aspects of this therapy are helpful or unhelpful in the process of recovery. Four themes were constructed from the data set, 'Clinical Picture', 'Deciding to start DBT', 'Evaluation of DBT' and 'Change', with each theme containing between two and six sub-themes. As detailed in the visual thematic map, these themes are seen to connect with each other to represent a journey through therapy.

3.2 Clinical Picture

This theme relates to the participants' problems and life events which contributed to their difficulties. This was felt to be a relevant theme and an important starting point as the difficulties resulted in access to services and as such underpin the intervention received. The data from this section were found to cluster into two sub-themes; presenting problems and adverse life events (see Figure Four).

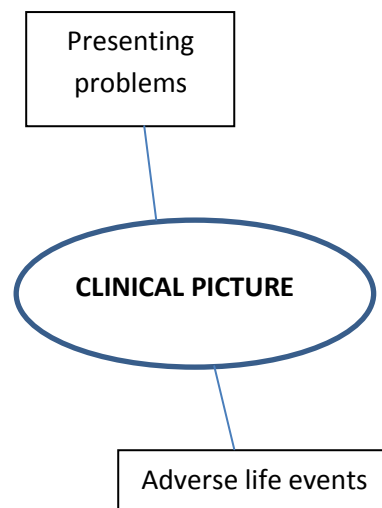


Figure Four: Extract from the final thematic map, showing the theme ‘Clinical Picture’

3.21 Presenting Problems

Participants discussed numerous problems which they found difficult to cope with and ultimately led to their referral into adolescent services. Although many similar problems were discussed, there were individual differences in the type and severity of the problems experienced, and each participant had a different cluster of presenting problems. Difficulties discussed included self-harm, suicide attempts, relationship difficulties with family, friends & partners, low mood, substance abuse, anger, anxiety, low confidence, poor self-image, isolation and difficulties communicating with others & talking about their problems. Some of these difficulties are highlighted in the quotes below.

“I was really sad. I didn’t like myself at all” (I2, 3, 73)

“[I] didn’t get on with my mum, didn’t get on with my dad....I had no family around me.....I went to spend [Christmas] with [my boyfriend]. Boxing day he wanted to go out and get on

drugs cause he did them as well, and he chunked me out into the streets with my Christmas presents that I had bought him. He said he didn't want any of them. That was really bad for me cause I had spent months organising all these perfect presents. I had spent a fortune. I was skint. It was horrible, breaks my heart..." (I4, 3, 71).

"I was self-harming quite a lot and it was like nearly every day, and I couldn't really talk to people like I didn't really know a lot about myself or why I was doing it" (I2, 1, 14)

Self-harm and suicide attempts were a key presenting problem discussed by all participants. Participants linked this parasuicidal behaviour with accessing services and the intervention they received. Self-harm and suicide attempts also appeared to be linked to how participants coped with their on-going difficulties.

"I was like having family problems and that, and like, always arguing with my mum cos she used to be very bad with her drinking, my brother was in care, so yeah I was self-harming and proper getting angry all the time" (I1, 1, 27).

"I took an overdose because I couldn't, I just couldn't cope with it anymore" (I5, 1, 25).

Participants' views on the difficulties that brought them into services varied. Whilst there was an acknowledgement of the role of self-harm and its links to the DBT intervention, many ideas related to systemic or victimisation difficulties, as noted in the next sub-theme.

3.22 Adverse Life Experiences

Participants' described numerous victimisation and adverse life experiences such as sexual assault, physical abuse and bullying. It appeared these life experiences were strongly related to on-going problems and in some cases linked to the onset of difficulties.

"Before all the bullying and that [sexual assault] you know everything was fine, everything was great you know. Good life. Loved my sports. Did everything you know..... and then obviously when everything happened it just, it kind of turned me around and I am still having problems now you know and I get dead angry dead quick and I am dead on the edge" (I5, 3, 74).

"It was more than self-harming.... like abuse and stuff" (I2, 1, 19)

As highlighted in the above quotes, victimisation experiences play a significant role in the access to services and also with on-going difficulties. This is an important consideration particularly as stage one of the DBT intervention, the focus of this research, does not target victimisation experiences. The lack of emphasis on victimisation and trauma will be discussed in a later theme 'experience of DBT'.

3.23 Summary of the theme 'Clinical Picture'

Multiple difficulties were described by all participants with a particular focus on self-harm and suicide attempts to help cope with on-going problems. Victimisation experiences also played a significant role in participants' beliefs about the onset of difficulties and continuation of such difficulties. However, whilst participants identified the significant role of their adverse

life events, there was an acknowledgement that the intervention related to the consequent presenting difficulties, notably parasuicidal behaviour, interpersonal difficulties and problems with emotion regulation. All participants described difficulties coping with their presenting problems and a need for help in this area; this was linked to their decision to begin Dialectical Behaviour Therapy.

3.3 Deciding to start DBT

This theme relates to participants' decision to commence Dialectical Behaviour Therapy. Data analysis identified two sub-themes which impacted on the decision making process; understanding of DBT and expectations of DBT, as can be seen in figure five.

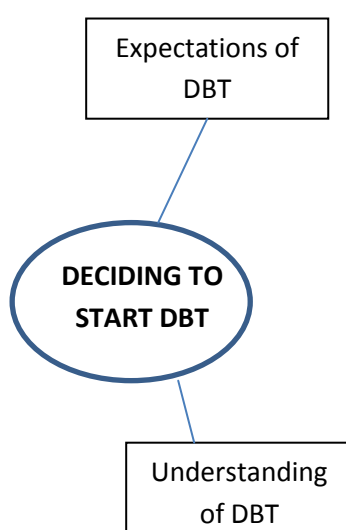


Figure Five: Extract from the final thematic map, showing the theme 'Deciding to Start DBT'

3.31 Understanding of DBT

Many participants reported being provided with little knowledge or information about DBT prior to starting therapy; this resulted in limited understanding about DBT and often led to increased anxiety and negative beliefs about what would happen.

“I thought it would be full of idiots; it won’t be full of people like me.... I thought it was going to be like 20 people and that put me off..... I thought there would be too many people for it to help me” (I4, 10, 310)

“...Well I don't even know what DBT stands for” (I1, 7, 258)

“[I was nervous about] like meeting new people and what the group was gonna be about and stuff and what I'd have to do, I was very nervous and I didn't really understand anything about it...” (I3, 4, 151)

This lack of understanding and associated beliefs and emotions did not appear to impact on participants’ decision to start DBT. It is likely this was due to a desire for improvement with their problems, with a significant reason for joining DBT relating to the belief that their problems were at a level where intervention was needed.

“[I joined because] I was desperate” (I4, 10, 321)

“..... I just thought I would try it cause I was pretty bad” (I2, 2, 65)

As can be seen from the above extracts, participants describe feeling their problems were difficult to cope with prior to the commencement of DBT, with the decision to start therapy not related to their understanding of DBT but rather a desire to feel better.

3.32 Expectations of DBT

Whilst it seemed that any intervention would have been accepted in an effort to reduce the presenting problems, a key factor in deciding to join DBT for some participants related to not just a desire for improvement but also an expectation that DBT would improve their situation.

“I thought it was for a bit of like anger management and self-harm and they'd be telling you like ways to like alternatives to self-harm and like help me with my anger... cos I get angry really easy and when I'm angry I self-harm. So I thought oh it'll do me good” (I1, 7, 268)

DBT facilitators' explanations of and belief in the benefits of DBT also played a key role in the decision making process for some participants; with this impacting on their expectations about the benefits of DBT.

“(DBT therapist) just, she talked me into it really. Well not talked me into but you know she was trying to persuade, saying how good it'll be for me so I said yeah I will do it” (I4, 1, 336)

“(DBT therapist) mentioned it to me cause he is my, he's my counsellor and yeah he mentioned it to me and I thought it, I thought it would be good for me you know..... they told us it was about different skills that you know that could help us out, obviously if we try and do it, it will, it will most probably definitely help us out” (I5, 3, 96)

Unfortunately for some participants, the expectation and understanding of DBT generated from discussion with the DBT therapists did not match their experience, as depicted in the quote below:

I don't know really cos (DBT therapist) said it was like, for anger and self- harming and like when he was talking to us it weren't, it didn't really come across as self-harm d'you know what I mean? It was just like the mindfulness thing that we did, it was just like.. like they were saying put your thoughts into a leaf and watch em go by or something and I was thinking I'm not a 'retard', and I just, I don't know it's just weird; it weren't for me that group. (I1, 2, 82)

The implications of participants' expectations of DBT in terms of perceived benefit from therapy will be discussed in a later theme, 'Change'.

3.33 Summary of the theme 'Deciding to start DBT'

The decision to start DBT was clearly linked to participants feeling that they needed an intervention to help them with their on-going difficulties. It appears the information on DBT supplied by the therapists to help with this decision making process was inconsistent, with some participants having limited understanding of DBT and what it could offer, or alternatively the information presented resulted in expectations which were not met. Whilst the information provided did not seem to impact on participants starting DBT, as will be discussed in a later theme, it seems this did have an impact on whether their evaluation of the benefit of DBT and ultimately whether they remained in therapy.

3.4 Evaluation of DBT

This theme explores participants' evaluation of their therapy experience. Data analysis resulted in two sub themes; 'Negative Aspects of DBT' and 'Positive Aspects of DBT', as can be seen in Figure Six below. Participants discussed a number of factors which they linked to positive or negative experiences. Some of these factors would relate to any therapy received

and as such are labelled 'common therapy factors' whilst others relate specifically to DBT and are therefore labelled 'specific therapy factors'. As can be seen in Figure Six, the two sub themes contained both common and specific therapy factors relevant to the participants' therapy experience.

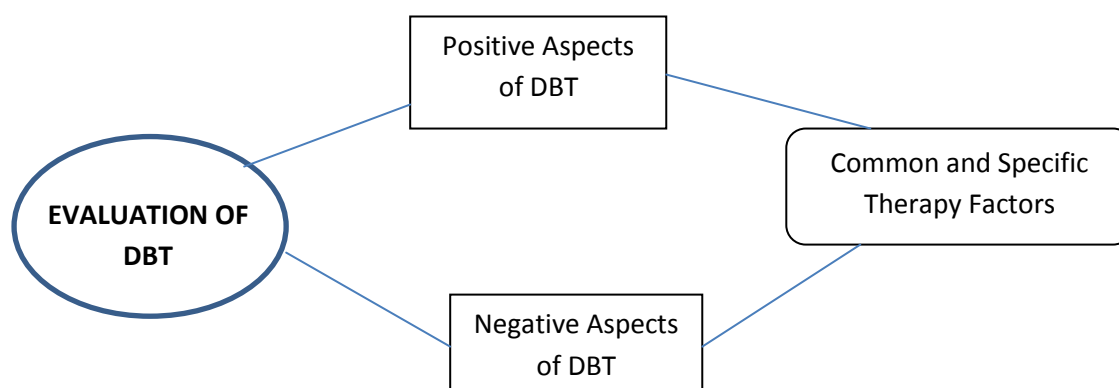


Figure Six: Extract from the final thematic map, showing the theme 'Evaluation of DBT'

3.41 Negative Aspects of DBT

Participant's discussed a number of factors which they felt contributed to negative experiences in therapy. It could be argued some of these negative aspects would have arisen regardless of the therapeutic modality. A significant common therapy factor discussed relates to the experience of meeting group members at the outset of therapy. As depicted in the quotes below this was often referred to as a difficult process resulting in nervousness & anxiety as well as concern about what to expect.

"It was quite scary because it was like I was meeting loads of new people. I think there was about five of us like including the staff people and yeah it was scary cause I didn't really know what was going to go o- like happen" (I2, 3, 95)

"It was quite hard at first cos I don't associate with many people..... [It was] very nerve-wracking. I was dead nervous. Yeah.. like meeting new people and what the group was gonna be about and stuff and what I'd have to do, I was very nervous and I didn't really understand anything about it" (I3, 4, 144)

Linked to this anxiety about meeting new people were difficulties related to opening up and talking to group members about personal experiences.

"With me I am not very, I can be, but I am not very good at meeting new people. Like I say I don't really like, I don't really like talking about my stuff, when if there's, one person I can, if there's quite a few it just gets me a bit on the edge because it is like there is a load of people around me and I don't really like it" (I5, 5, 153)

For some it was hard to overcome these initial difficulties of meeting and talking to group members. As depicted in the quote below this could result in a perceived lack of benefit from attending and a decision to end therapy, particularly in light of competing time demands.

"When I first went it (pause), I'm scared when I first go to anything, like today in work basically, and I was scared and I was dead nervous and I didn't know anyone so that day I didn't really say anything and then the second session I spoke a bit more.... and I'd open up

a bit but not like the others , I just thought I don't, I thought it weren't for me and like I think, I kept thinking I've got to have time off at college and that to go to it" (I1, 2, 69).

Another significant common factor impacting on the experience of therapy related to the DBT therapists. The therapeutic relationship was identified as an important element relating to therapy experience. As can be seen in the quotes below, it can be difficult to develop rapport where participants feel like they can talk to and be helped by the therapists. The negative impact of this is also highlighted in the quotes where participants discuss escalation in difficulties or dis-engagement in therapy.

"The one to ones? Mmmmm they were alright, I didn't really like them as much but I've changed who I see now and my one to one worker I've changed so I like him a lot more.....She was very 'by the book' she did things by the book and I didn't like it. Erm, yeah, she weren't very easy going. The one I'm with now, he's lovely (coughs), he erm, yeah. [Before] I just didn't like it really very much. I didn't feel like she were helping me" (I3, 5, 177)

"it's not just [DBT facilitator] it's all just CAMHS the way they speak to you, s'like, they talk to you proper slow and like calm and I just thought I'd rather you talk to me normal and it was doing me head in and I just couldn't speak to them and erm I couldn't tell him how I felt or nothing. I just used to lie so then I could get, like, so they weren't involved but then like cos I weren't speaking to anyone then I start going off the rails again" (I1, 4, 136)

"I hated it. I didn't like [DBT therapist] Just I don't know, I got a funny vibe off her and she called me a 'drama queen' a lot and the actual word she used was 'drama queen' and that upset me.....I never argued with her. Never said a bad thi- thing to her but you can ask my

dad I never liked her and he had his counsellor who was lovely.... He's dead nice and just, just lovely man and I had someone who I didn't like looking, seeing, that was hard, and I always wished myself why couldn't I have [him] cause I would have lasted, I would have had such a good time...I would have looked forward to the sessions" (I4, 23, 725)

Participants also reported feeling pressured by the facilitators to engage in sessions when they did not feel comfortable doing so, therefore impacting on motivation and desire to attend.

"[DBT therapist would] give us this sheet to take home and then bring it back the next week and erm, write if you felt like self harming what did you do instead of that? And what caused...or if you did self harm, caused you to do that? And they was like read it out and telling him and there was this woman who run it as well and they was just telling him how, what happened and if they self harmed or if they did something different and I didn't want to say mine out loud. And he was like, just say, just say one of them and I just didn't want to (I1, 4, 161)

[I feel} quite stressed actually [after group sessions], because, it's like....you feel...like you've got to and they'll go around and ask you each questions and stuff and it's kind of like putting you on the spot (I3, 8, 305)

A number of negative factors were also discussed by participants which related specifically to DBT. One of these specific therapy factors related to the homework, which is an integral element of DBT used for skills practice and skill generalisation. However participants

reported a dislike of completing homework due to a lack of perceived benefit from this process and also negative links between DBT homework and school. Participants also described a dislike of sharing their homework with the group, particularly if the content was difficult to talk about.

“The homework at the DBT group, right because.....I don’t know, it reminds me of being back at school and I don’t like doing it and it just doesn’t help writing something down to go and share with a load of people” (13, 7, 280)

“[I didn’t like] the homework because it reminded me of school and I hated school. Despised school. Not, well, well despised the work but it just reminded me of education. I don’t like anything to do with education now” (14, 18, 586)

“[I didn’t like] talking about stuff. Sometimes I did but then like when we have got the homework and if it something real bad I didn’t like sharing it round with everyone and yeah just sharing homework back and that, you know I’d rather, sometimes I’d rather keep it to myself instead of giving it around” (15, 9, 272)

Some participants also discussed dissatisfaction with the session content in both group and individual sessions. It appeared the content was not always felt to be relevant to current circumstances and difficulties, resulting in a perceived lack of benefit and, in some cases, disengagement.

“I don’t know how to explain it but if I go in upset and really only things to do with relationships but I am not upset cause of relationships it doesn’t really help” (I2, 8, 257)

“I don’t really like my individual sessions to be honest. I don’t, I had them for quite a while and, but when, when you’re in the DBT group the s- in the individual session that is all you ever talk about so you are just talking about the group and that which at the end of the day I’m there for something that happened at Christmas....” (I5, 9, 284)

All of the participants discussed difficulties with the emotional impact of attending DBT sessions such as feeling stressed, angry or upset after attending. These feelings could arise due to the impact of talking about their own difficulties in group and/or individual sessions, but also from the impact of listening to others in group sessions.

“sometimes were down..... cause I have talked about, I have talked about stuff that has been bothering me, so obviously I am talking about and it is coming back in my head, so, but you know my girlfriend came and met me so we just used to meet up and just talk to her about it and that, and she would just, obviously she would talk to me and I would just feel a bit better. She hates it when I go in though cause sometimes I can c- I can be really bad afterwards and really moody when I come out of them” (I5, 10, 310)

“I always used to get very sad cause I just thought what a lovely girl and it is just so sad to see, it was sad to see such nice people be down and how, and I could understand why all my family were looking at me thinking p-name feeling down is not nice. And to look at two

girls who I'd not known that long and it got me down thinking that they were down weren't nice" (I4, 17, 527)

Participants were open about the emotional impact of DBT sessions and this negative aspect it was identified as one of the reasons for not attending.

"I just knew myself that I wouldn't be able to cope there, I'd probably if I had, if I'd had a bad day and I was upset I would probably just burst out crying there and obviously I'd just, I would walk out cause I knew I wouldn't want to be there so" (I5, 6, 181)

[I didn't go because] it was hard getting up at that time, when you have not slept for four days you were going sleep on a Tuesday crying cause you were feeling crap..... it was hard cause I had no motivation cause it was sucking it out of me, this depression and this down, down feelings was sucking all motivation out of me (I4, 17, 557)

Finally, a significant negative aspect of DBT discussed by the participants related to the difficulties with the skills learnt in DBT. Difficulties discussed related to the complicated nature of the skills which impacted on participants' understanding and use. In addition participants described difficulties in applying the skills outside of the DBT sessions; this related to the need to practice skills, which in itself was a source of contention but also due to perceived difficulties in applying skills in real-life situations, particularly when emotions were strong.

“Well they try and teach you mindfulness, but when you're actually going through what you're going through, mindfulness doesn't even come into it. Erm, it helps cos I can go there and I can talk about things but as for using the stuff I found it very difficult” (I3, 6, 239)

DBT for me the good bit I got out of it was making friends.. yeah, rather than the skills because I think it was very complicated some of the stuff (I4, 15, 485)

I just used to, I just always used to like I say distract myself and that as well but now I can't, I can't seem to. It [emotion] just takes over me (I5, 13, 394)

[Skills I found hard like}...the mindfulness, erm, there's like different ones of letters that mean words and stuff which are quite hard but the mindfulness is hard... (I3, 7, 255)

Individual factors in the use of skills were also noted with participants having a preference for certain skills and difficulty with others. However some participants discussed dis-satisfaction with the skills in general and expressed a desire for a wider variety to help meet their individual needs.

“I haven't used every skill cause sometimes I just don't, it just doesn't help me but I think it is all useful..... just if, probably if you don't feel comfortable doing it like I think there was one where like you had to like monitor your moods and stuff but that didn't really work for me because I didn't really know how I was feeling” (I2, 6, 183)

“[I’d like] erm, a bit more erm, a few more skills cos some skills just don’t suit certain people and I don’t reckon they have a wide variety of skills.....” (I3, 11, 405)

Whilst there were a number of negative aspects related to participants’ experience of therapy, a number of positive aspects were also highlighted.

3.42 Positive Aspects of DBT

Participant’s discussed a number of factors which they felt contributed to positive experiences in therapy. Again it could be argued some of these positive aspects would have arisen regardless of the therapeutic modality whilst others are specific to the DBT intervention.

A significant factor discussed by all participants relates to therapeutic factors. As noted previously, therapeutic factors relate to the beneficial effect of group processes on individuals and occur in any therapeutic group regardless of therapeutic modality (Yalom; 1975, 1885, 2005). When reflecting on the group element of DBT a key therapeutic factor described was group cohesion. Participants noted the benefits of receiving support from others and group cohesion was linked to positive emotions and perceived benefit from attending the group sessions.

“.....and the next week I went and we had more to talk about because you know we had spoke and it was like, you know everyone became more closer and everyone was chatting more and I think that’s the best thing for me” (I4, 12, 368)

"[The group was] helping out really, It was enjoyable. Good people to talk to, and everyone just understands you, so you know that you've got people there for you" (I5, 11, 328)

".....I just wanted to go and he was like just see how it goes and that, and I stayed there. I stayed there for the full group and I felt a bit better to be fair cause I, I knew I was with people that I obviously I know now, and I know I can speak to someone" (I5, 6, 196)

Linked with group cohesion were the therapeutic factors of 'acceptance' and 'universality', with participants describing a feeling of being accepted and belonging in the group, as others understood them and had similar problems. Meeting and talking to people with similar problems was found to be extremely helpful for participants as they had previously felt isolated and alone.

"The best thing about DBT is the fact that we can just sit there and talk rather than doing the task, filling out sheets. It was the fact that we were just sat in a group talking with people who weren't going to judge you and they had been in a similar situations" (I4, 12, 371)

".....I felt better than I thought...before that I was like 'why is it always me?' and then I went to the group I thought 'God there is people in my position and there is other people that are going through the same.'" (I1, 3, 117)

"It was weird cos I thought I was like the only one (laughs).....but it was, yeah, helpful to know that I wasn't the only one, there was other people out there that suffered with the same things that I did" (I3, 5, 169)

The benefits of listening to others was also highlighted by participants; this could help them find different way of coping with their difficulties and also lead to hope that they could make positive changes similar to those identified in other group members.

“Yeah it [DBT group] is useful because you know if it happens to you, you know what to do when [others] are telling you, like advising you what to do and how to do stuff so yeah it does get helpful sometimes” (I5, 17, 551)

“Other people are going through the same thing and like, I don’t know, if you say you don’t do it this way they can tell you sort of another way of what you could try and I feel better...” (I2, 4, 128)

“When we do the homework like some people like use the same examples but I noticed this one person like got closer to someone, like they are not really arguing that much anymore cause like she uses the skills and ... I forgot what I was going to say, but yeah I think people have got better..... it feels good cause I know like that if it works for them then it can work for me” (I2, 8, 245)

The concept of ‘catharsis’ was another therapeutic factor discussed. Participants described benefits from attending and talking about their problems, for some people this related to having a place where they felt comfortable to do this.

“Sometimes I feel I have got stuff off my chest so I feel better about it so when I am going home I feel fine” (I5, 10, 322)

“Like sometimes I go there like crying or something and then I just come out feeling better cause we just like talk about things and makes you understand it, and I just like the atmosphere and stuff” (I2, 8, 238)

Participants also discussed the importance of the DBT therapists’ role. The techniques used by the therapists to help explain skills and encourage participation were found to have a positive impact on therapy experience, with participants feeling this helped with their understanding and motivation to participate.

“I think they [DBT therapists] have been good because they don’t just do it in one way if you know what I mean, like they don’t just write down, they like sometimes they use like the white board and like I don’t know I remember once like they got loads of like black pom poms and then bright coloured ones and you could see like difference in, it’s just like they give you loads of ways to clear your head if you know what I mean and like they are just really nice so” (I1, 11, 355)

“[DBT therapist] came in and he explained the raffle tickets and I love that, because I just like rewards, like little rewards like that. Even just getting up to get something. And the prizes were like hot chocolates and just what I needed, and I won the first day and basically the more you input the more you get a raffle ticket and that’s a su- and I think that is just an amazing thing. I think that was one of the best things because it encourages you. It encouraged me to do it anyway cause I liked the ha- havi- winning. I liked inputting” (I4, 11, 350)

The importance of the therapeutic relationship was also highlighted by participants. The benefit of having a good relationship with the therapist was noted to have an impact on whether the therapy experience was found to be positive or negative. The quote below highlights one person's experience of previously working with the therapists involved, with this relationship helping them feel more comfortable.

"well one of them I knew cause it was [DBT therapist].. I knew the other one as well cause I had spoke to her before, when obviously [DBT therapist] is not in I normally speak to her but yeah get to know them then and that and knowing they're there as well it just means, it just means a lot....if it was someone different it'd, for me it would have been a bit awkward like because I'd, I'd have to get to know them and it would take me a while to get to know them and that but cause I knew them it was easier to talk out again as well because I know I am talking to the person I know" (I5, 5, 159).

Positive aspects of DBT were also noted in terms of benefit found from individual sessions, with the therapist again playing a significant role. Participants discussed the importance of the therapist factors; for example feeling confident in the therapist's ability and also feeling comfortable talking to them.

"It's like cos you can get your opinions out in there and you can say what you want and no one's there judging you and you can talk about problems with someone who's qualified to give you the advice" (I3, 8, 291)

Some participants described feeling more comfortable talking about the difficulties in individual versus group sessions, with this found to be a positive and helpful element of DBT.

“[The individual sessions were more helpful].....I think it's cos I could like open up more, not in front of all the other people” (I1, 4, 157)

Some participants described how the individual sessions contributed to a positive experience of DBT for them as the sessions were more individualised and personal to them, and as highlighted in the quote below, enabling a discussion about problems that are not relevant to a group session.

“Sometimes I get a good session out of it sometimes I don't.. [they are helpful if] like I am talking to him about my problems, because I know he is there to help then [but they are not helpful if it's] talking about DBT group and just blabbering on” (I5, 9, 292)

3.43 Summary of the theme ‘Evaluation of DBT’

Participants described a number of negative and positive aspects of DBT that contributed to their overall experience of therapy. These aspects relate to both ‘common factors’ which could be attributed to any therapy, and also to ‘specific factors’ which are attributed to the core elements of DBT. Therapist factors played an important role in the experience of DBT with therapist style and skill contributing to the perceived helpfulness and benefit of therapy. Group members also played a significant role in participants’ conceptualisation of their DBT experience. Whilst meeting group members and talking about personal problems in front of them was difficult, the development of the group relationship contributed to a positive

experience as a result of perceived understanding and support from others. DBT specific skills were found to be another significant factor contributing to either a negative or positive experience, with some participants finding the skills extremely helpful, whilst others struggled to understand the concepts or apply the skills in a meaningful way. Overall it appears that common factors, most notably therapist and group relationships, had more of an impact on a positive therapy experience than specific factors relating to the DBT model.

3.5 Change

Data analysis revealed five sub-themes associated with this main theme, as can be seen in Figure Seven below; 'identification & attribution', 'motivation', 'impact of others', 'recovery', and 'future'. This theme relates to the outcome of DBT, whether participants perceived an improvement in their difficulties and if so the attributions made to this change. The theme also relates to motivation to change, participants' concept of recovery, the significance of other people in the change process and participants' hope for the future.

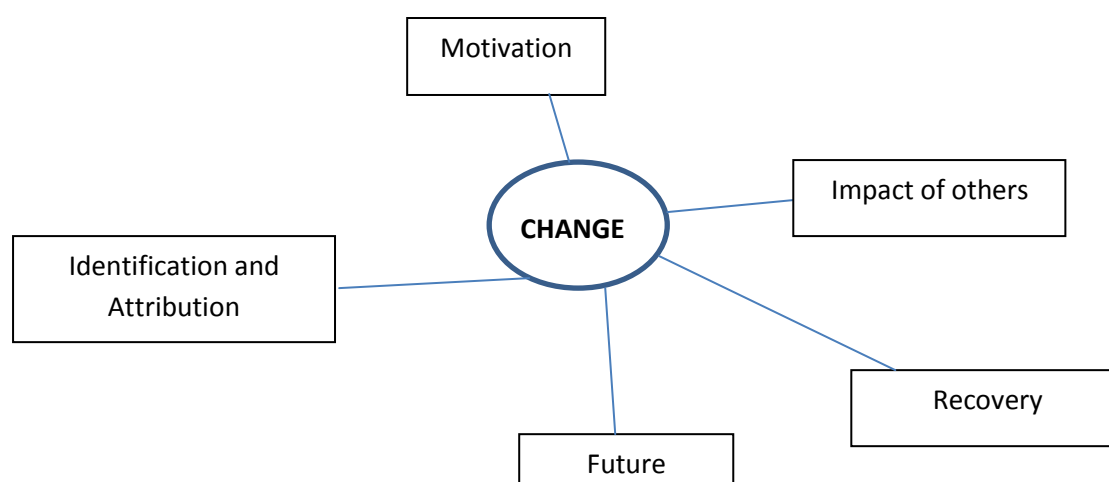


Figure Seven: Extract from the final thematic map, showing the theme 'Change'

3.51 Identification & Attribution

This sub-theme relates to whether participants were able to identify any change as a result of receiving DBT and if change was identified, whether this was felt to be a result of the DBT intervention. Some participants struggled to identify a change in the difficulties they were experiencing at the onset of therapy. This often resulted in a feeling of dissatisfaction with DBT as it had not met with their initial expectations, and consequently resulted in a lack of hope about change, and for some disengagement in therapy.

“I don't/ I won't go back to that group again..... I just thought it was pointless in even going” (I1, 5, 184)

“Yeah it didn't feel like it was helping me, that the group was helping me to st...like stop [self-harming]” (I1, 3, 91).

“[DBT was] not for me because no matter what skills you got you can't get off the way I was feeling because when I was down I was down” (I4, 15, 475)

Other participants were able to identify a number of positive changes with the difficulties they had been experiencing and felt the DBT intervention had helped with this. Overall the changes discussed primarily related to an improvement in social skills, an improvement in mood and a reduction in parasuicide and self-destructive behaviour such as substance misuse.

"[DBT] has sort of made me more confident speaking to people as well cause I have got like sort of steps to speak to people with so that's good" (I2, 7, 214)

I don't think I did self-harm once when I was in DBT. Not quite sur....of what I remember I didn't but yeah it was really helping out (I5, 11, 333)

"I liked learning new skills like that as well cause I know now cause I have got a folder upstairs of all of the them in so I know now that if I am feeling down all I can do is just go and look in my folder, see what can distract me or something like that and try it out" (I5, 8, 254)

"I don't really talk to her [mum] about like mental stuff, like moods and stuff but we are closer like when we go out with each other and I think we are closer but at times we are not so it is better than when I first started though.... I think cause I know how to talk to her and like I am not that bothered about, like when we learnt how to sort of recognise our emotions and like how to sort of get them back to normal again I sort of know how to do that faster and like easier so I can like be around people so I think that helps" (I1, 7, 219)

The quotes above highlight how DBT, and in particular DBT skills, appeared to help participants make positive changes. Whilst some participants attributed positive change to the DBT intervention, others instead attributed change to factors such as internal motivation or external support.

"Well I'm not drinking and I'm not on drugs any more.....I don't think it's got much to do with the group.....That was through erm [my partner] actually. Yeah [my partner] helped

me..... Erm, well I was going through a really difficult time and [partner] was, said it like, had to stop and erm, she helped me by supporting me and stuff” (I3, 9, 346)

3.52 Motivation

As noted in the previous sub-theme, participants were able to acknowledge their own role in the process of change and discussed a desire for improvement in their difficulties. It appears this was particularly relevant for some participants who described reached a ‘turning point’ in their lives, resulting in motivation to change and consequent improvement in difficulties; this improvement was not linked to DBT in all cases with motivation to change occurring after some participants had disengaged from DBT.

“Yeah I just think cos when I was like feeling like really bad, I was really bad, never been that bad before an I was just having mad thoughts and I'm just surprised that I didn't kill myself I was that bad and then I just woke up and I just thought you just need to get a grip now and be strong and like not let the past get me down and just think about my future” (I1. 7. 280)

“Cos a few, about 3 weeks ago I was really bad like dead down and never, never been that down before and erm, I was having really bad like suicidal thoughts and that so I rang [DBT therapist] and erm, he was worried so he got the home treatment team to come out and see me like every day for a couple of days. and then I was really bad for about a week and then I just woke up one morning and I just thought 'you need to sort your head out now and.... well your life's what you make of it so make it good....' and since then I've been doing well” (I1, 5, 200)

“[Change was because of...}Me. Sometimes I don’t like receiving help, so I received the help which made it better so I know now to get, I know now to have help because I know it gets me better, I know it makes me happier, less stress so yeah” (I5, 11, 350)

3.53 Impact of Others

This theme does not relate directly to DBT, rather the importance of other people in the change process. For some, support from their partner, friends or family was an important factor in helping them to improve their mood, engage with therapy and also practice the skills when needed. The quote below demonstrates the positive benefit found from a supportive partner.

“I would ask my girlfriend to come up because when I am on my own I think more because obviously you are just on your own and you just thinking and thinking so I would ask her to come up and I’d, she would ask me what’s up and that and I would like I just want at the moment in time I just want to chill out for a bit, I just want to, I just want to have a cuddle and that and then I would tell her later on once I had calmed down a little bit” (I5, 7, 207)

The role of others was also important in helping participants identify the need for service support and also identify positive change.

“Since I have started CAMHS I think she [mum] has noticed that I have got better like cause my self-harm isn’t that bad anymore and I am more like, like out if you know what I mean.. like I go out with friends sometimes” (I2, 9, 285)

“[My partner] wants me to go back cause she obviously you know she just thinks I’m moody all the time so ((laughs))” (15, 16, 510)

However other participants described how the difficulties they experienced in their interpersonal relationships impacted on their presenting difficulties and their ability to make positive changes. For example, as described in the quotes below, difficulties with interpersonal relationships had a negative impact on participants’ mood.

“I met [my ex-partner] and within that week, looking back on it now, within that week he started that psychological abuse but he was my first love, and my only love. I have never loved anyone else since. I can’t cause they are not him..... [My ex-partner] was my mood, and [my DBT therapist] said that. [My DBT therapist] said no matter what else is going on in your life [your partner] is your mood. He controls whether you are happy or sad. I said yeah (14, 16, 496)

“I don’t really get on with my mum. I never really get on with my mum. We are not really that close, and she doesn’t like it you know when I don’t talk to her about stuff but I don’t, I don’t really like talking to her..... I took an overdose coup- couple of months ago and I was like I had to have treatment, I had to have everything because it was like dead fatal and she just, and something she came out with was just, it was pretty horrible to say.. She just came out with ‘ I don’t know why you are living with me if you didn’t, never even want to talk to me’, and it just shocked me a little bit. Made me really upset.” (15, 2, 46)

Difficulties with interpersonal relationships were a significant presenting problem for the participants, and ultimately a feature of BPD. The findings that interpersonal support can have a positive impact on the change process, suggests it is important to involve significant others in DBT.

3.54 Recovery

All participants described on-going difficulties linked with their presenting problems; although for some these difficulties were to a lesser extent than when initially seeking support from services. Participants' concept of their recovery related predominantly to improved mood and confidence coping with difficulties on their own. Significantly, participants also referred to other people noticing these positive changes, again highlighting the importance of involving significant others in the DBT process.

"if I felt like a 100% better or like.... that if I get upset I can like manage it and I don't really need help anymore so..I think other people might notice that I am like happier and like more confident" (I2, 9, 273)

Whilst discussing on-going problems, some participants identified improvement in their trauma related difficulties as a significant feature of recovery. The quote below, for example refers to a participant who became isolated and agoraphobic following an abusive incident.

Erm I don't know er..... (long pause) my moods would improve and stuff and..... get like, get better and stuff.....I'd be a lot more happier and people would notice that....I'd be a lot

happier in myself and I'd be able to go out more and stuff.....The day I can, like, go out and go to [town] on my own is probably the day I'll start feeling better (I3, 13, 496).

3.55 Future

Some participants described feeling the need for on-going contact with services with these participants hopeful that positive change would occur in the future as a result of DBT. However some participants described also feeling worried that this change would not occur and contact with adult services would be needed.

"I'm worried. cos I haven't gained that much from it [DBT] so far but if I carried on with it, it could get better and I could relearn stuff cos I don't remember half of it erm, yeah. Quite worried actually..... cos I'm not just gonna (clicks fingers) get better like that am I? So yeah"
(I3, 12, 477)

Ultimately whether continuing with DBT involvement or not, participants described a desire to feel better and continue to improve with their difficulties, resulting in a feeling of progression in their lives, for example through education, work or starting a family.

"I just want to like stop self-harming and then maybe get back to college and stuff, and then like go to uni" (I2, 10, 323)

3.56 Summary of the theme 'Change'

Change or improvement in presenting difficulties was an important theme to arise from the data analysis. The concept of change and whether this had occurred was different for each individual. Some participants reported no improvement in their difficulties as a result of receiving DBT, and consequently this led to dis-satisfaction with services and the intervention offered. Some participants did note some improvement in their presenting difficulties; however the identified change was not to a degree where they felt they had 'recovered'. The identified change needing to occur before participants felt they had 'recovered' from their difficulties again differed with each individual, and importantly, for some, this related to aspects such as trauma, not covered in stage one of the DBT programme. The importance of others in the process of recovery was also noted, notably with significant others being either a help or a hindrance to this process. Ultimately, whilst identified change or improvement in difficulties was low in frequency, participants remained hopeful about their future, either in terms of their own motivation to change regardless of therapeutic intervention or hope that DBT would result in an improvement from their difficulties.

CHAPTER FOUR: DISCUSSION

This chapter provides an overview of the aims and findings from the study. Where possible the findings will be discussed in relation to previous research. Towards the end of the chapter consideration will be given to the limitations of the study and the clinical implications along with potential future research will be highlighted. Finally a reflexive account of the process and impact of the research on myself will be discussed.

4.1 Overview of the Study

This research study was exploratory in nature and aimed to expand current research on the effectiveness of DBT by exploring adolescents' experience of receiving this therapy. Participants' therapy experience including onset of difficulties, presentation to services, receiving therapy and recovery were explored using interviews, with the hope of identifying the most and least helpful aspects of the therapy process. Verbatim transcripts of the interviews were subsequently analysed using Thematic Analysis to explore and construct themes across the entire data set. In summary, four main themes were constructed from the data; 'Clinical Picture', 'Deciding to Join DBT', 'Evaluation of DBT' and 'Change'. Chapter three presented these themes along with their relevant sub-themes, with thematic maps and direct quotes used to illustrate and support the analysis. The themes were seen to connect with each other to represent a journey through therapy.

4.2 Research Findings

The study aimed to consider an adolescent's perspective of DBT and contribute to previous research exploring the effectiveness of this therapy. Each theme will be discussed in turn, and where possible links to previous research will be made and clinical implications highlighted.

4.21 Clinical Picture

Previous research has indicated that presenting difficulties for BPD can be extremely distressing for the individual and result in numerous contacts with services (Blum et al., 2008). Presenting problems have also been found to differ in number and severity; as such BPD is deemed a heterogeneous disorder with potentially hundreds of different clinical presentations (Asnaani, Chelminski, Young, & Zimmerman, 2007). Similar to Blum et al., (2008) the current research found that participants accessed services due to difficulties coping with their presenting problems. In addition, whilst there was some overlap between the presenting problems in this study, they were quite varied for each participant resulting in differing presentations, as found in previous research. The differing clinical presentations support research on the heterogeneity of BPD, however it is possible such variation could create difficulties in accessing appropriate support due to the flexibility needed from services to accommodate multiple and varied difficulties. Indeed problems in this area were raised by the adolescents in the study who reported feeling the DBT intervention was not targeted at their individual needs.

Whilst numerous presenting difficulties were discussed, each participant identified parasuicidal behaviour as one of their presenting problems and felt this was the main focus of the DBT intervention. Each participant also discussed trauma and victimisation experiences as resulting in, or contributing to their parasuicidal behaviour, and in fact, all of their presenting difficulties. At times this led to dissatisfaction with DBT as participants felt the need to explore their adverse experiences rather than focus on current behaviours. In light of this, the need for trauma work with this client group is an important consideration. Previous research has found a link between adverse life events and a BPD presentation (Al-Alem & Omar, 2008; Paris, Zweig-Frank, & Guzder, 1994; Zanarini et al., 2006), and whilst trauma work is identified at stage two of the DBT model, it appears that for some individuals

this intervention needs to be considered sooner. These findings also question whether trauma work should be central to a BPD intervention. Further research exploring the perceived need for and benefits of trauma work for individuals with BPD would therefore be helpful.

4.22 Deciding to Join DBT

In this study participants discussed their decision to contact services and start DBT, an issue which does not appear to have been explored in the research literature discussed in Chapter One. Previous research has found that only a minority of adolescents with emotional and behavioural difficulties will seek help for their problems. It appears the decision to contact services is more likely if the adolescent is able to identify there is problem, has had previous exposure to services and has external support from family and/or friends (Saunders, Resnick, Hoberman, & Blum, 1994; Zwaanswijk, Verhaak, Bensing, Van der Ende, & Verhulst, 2003). More specifically, Saunders et al (1994) found that female adolescents with suicidal ideation were the most likely to identify a need for help with their presenting problems and consequently decide to seek support from services.

Similar to this, participants in the current study reported seeking help from services due to a desire for help with their presenting difficulties, with this desire for improvement playing an important role in their decision to commence DBT. In addition, the role of the facilitators discussing the benefits of therapy was found to be important contributing factor in their decision. However participants unanimously reported limited understanding about DBT or what to expect from therapy. It appears they would have agreed to commence any therapy, not specifically DBT, in the hope of alleviating the presenting problems they were struggling to cope with.

The one session pre-therapy conversation with the facilitators resulted in positive expectations of change and improvement; however the experience of DBT did not always compare to the generated expectations, and for some resulted in disappointment and drop out. This finding has important clinical implications and supports the need for a comprehensive pre-treatment phase, as identified in the DBT literature discussed previously. These pre-treatment sessions would help to orient the adolescents to the therapy and also explore their commitment and motivation, therefore aiding them in making an informed decision about commencing therapy and ultimately reduce the potential of them dropping out of therapy.

4.23 Evaluation of DBT

Participants discussed many positive and negative aspects of their therapy experience. As discussed in Chapter Three, these factors were either specific to DBT or common to all therapies. It is important to make a distinction between common or specific factors in order to help draw conclusions about the effectiveness of DBT.

The adolescents in the current study identified feeling anxious and worried at starting therapy and also discussed difficulties engaging with the therapy process and talking about their problems. Previous research has identified a significant challenge in working with adolescents with BPD, due to difficulties with engagement (Chanen et al., 2009). It could be argued the inherent problems adolescents with BPD have in communicating with others will contribute to negative experiences when accessing a talking therapy such as DBT and consequently impact on their engagement. This has important clinical implications and it would be helpful to consider such potential difficulties when engaging a young person and assessing how they would benefit from therapy.

Previous research has found that an adolescent population is more ambivalent and resistant to change than an adult population, due to factors such as developmental immaturity and stigma associated with accessing therapy (Oetzel & Scherer, 2003). In particular, research suggests adolescents are difficult to engage if there is a history of trauma and/or substance abuse (Saxe, Ellis, Fogler, Hansen, & Sorkin, 2005), as is often the case for individuals with BPD, and was the case for the adolescents in the current study. It is likely the difficulties with engagement described by the adolescents in this study would have arisen with any therapeutic intervention and highlights the difficulties this population experiences in accessing and receiving benefit from the therapy. As such, research identifying how to help engage these young people is an area that requires further exploration.

Participants also discussed a number of negative factors specifically regarding DBT, which often led to dis-satisfaction and disengagement. Namely these factors related to completing & sharing homework, feeling the sessions were not personally relevant, the emotional impact of attending DBT sessions and finding it difficult to understand and/or apply the DBT skills. These factors highlight the demands DBT can place on an individual and the consequent difficulties in maintaining participant engagement. It could be again argued that a comprehensive pre-treatment stage would help orient participants to the demands of DBT and also serve as a way to assess how best to communicate and deliver therapy to aid understanding. In addition a forum for the participant to discuss any difficulties they may experience with DBT could be helpful to ensure the therapy is flexible and adaptive to individual needs.

Factors contributing to a positive experience were also discussed by the participants. These were mainly common factors with the most significant relating to therapeutic group factors, such as cohesion, acceptance and universality (Yalom, 2005). These therapeutic factors

resulted in participants feeling supported and understood by their peers and ultimately not feeling alone with their difficulties. This appeared to be quite powerful for some participants who prior to therapy felt they “were the only one” with such difficulties. The positive benefit experienced from meeting others with similar problems raises the question of whether a support group would be helpful for this population instead of a talking therapy. It could be hypothesised such a group would offer a positive experience without some of the negatives associated with therapy e.g. homework. A support group would also be a cost effective and accessible intervention to services. In addition, as participants reported finding it difficult meeting new people, it would be beneficial to identify whether a fixed group would be viewed more positively than the current DBT model which allows new members to join at the start of a new module.

DBT-specific skills were a significant factor contributing to either a negative or positive experience. As discussed previously some participants struggled to understand the concepts or apply the skills in a meaningful way; however others reported finding the skills extremely helpful. In particular self-soothing and distraction skills were described as helping participants cope with parasuicidal behaviour. It would be helpful for future research to explore on a larger scale these conflicting findings related to the DBT skills. For example clinical practice would benefit from understanding which skills are most beneficial to this population and why some participants find them useful whilst others do not.

Previous research in the area of common and specific therapy factors suggest that therapist factors such as the therapeutic relationship and therapist skill have a significant impact on treatment outcome (e.g. Messer & Wampold, 2002). This is supported by the current research where participants discussed how therapist factors contributed to either a negative or positive therapy experience. For example adolescents described how therapist skill and

flexibility in delivering the sessions increased their participation and understanding of DBT and therefore contributed to a positive experience of therapy. In addition participants noted that the therapy experience was more likely to be positive if they had a good relationship with the therapist, felt confident in their therapist's ability and if they felt able to talk to the therapist about their problems. If this was not the case then higher levels of disengagement from therapy were found. These findings highlight the importance of therapist factors in participants' engagement with therapy and demonstrate the need for appropriately skilled and qualified clinicians to work with this client group.

Finally, as noted previously, there was a large drop-out rate from the DBT intervention in the current study. This drop-out rate is a possible indicator that the intervention was evaluated negatively by the adolescents who took part. Disengagement could be related to numerous factors which have been highlighted such as lack of a comprehensive pre-treatment phase, dis-satisfaction with the DBT model, lack of motivation and commitment or the limited experience of the therapists in running a DBT programme. Whilst these factors have been discussed by the participants in the study, it is difficult to draw firm conclusions as many participants who disengaged from DBT declined to participate in the current research. Further research in this area would therefore add to a thorough evaluation of DBT.

4.24 Change

The two prior qualitative research studies which explored the effectiveness of DBT had mixed findings. One study reporting positive findings, in particular in terms of reduction in self-harm (Persius et al, 2003), whilst the other study reported more negative findings and little change in presenting difficulties (Hodgetts et al, 2007). The current research also found mixed results; participants were able to identify some changes such as a reduction in self-harm behaviour and an improvement in social skills, however overall participants mainly

found DBT resulted in little improvement and as such did not meet their expectations for change. These mixed findings suggest further research is needed in this area, particularly as there is research evidence supporting its effectiveness with adults (e.g. Linehan, 1993). Perhaps the age of intervention is a key factor for the differences in findings and an important consideration for future research. In particular as some of the adolescents reported some benefit from DBT whilst others did not, it would be helpful to explore whether specific individual factors play a role in change.

For the participants who did notice some improvement, although the use of some of the DBT skills were identified as being helpful, it was interesting to note that change was unlikely to be attributed to therapy. Instead participants reported positive change was due to their own motivation to change or as a result of support from others. This finding suggests it is important to consider the role of motivation and external support in the outcome of therapy. Indeed participants noted that lack of motivation and lack of support impacted on engagement with therapy and in some cases resulted in an escalation of problems. However the finding also raises the question of whether an attribution bias plays a role with this population, resulting in difficulties identifying benefit from service input. Tustin (2000, 2002) suggests individuals with BPD demonstrate an attribution bias whereby they assign positive causality to themselves and negative causality to others and as such may respond negatively to therapy where they are required to take responsibility for negative behaviour. As the adolescents in the current study found it difficult to identify benefit from DBT and did not assign positive causality to therapy, further research in this area would be helpful to explore the role of attribution and its impact on engagement.

All participants reported on-going difficulties, with the concept of recovery different for each individual. It was interesting to note that recovery was often discussed in terms of

improvement from difficulties not specifically targeted by DBT, for example with an increase in depressed mood or with a reduction in trauma related difficulties. As these difficulties are not targeted by DBT, the effectiveness of this intervention alone for a client group who present with multiple and varied difficulties, is brought into question.

The multiple and varied presenting problems raise the question of what should be 'treated' and indeed what is being 'treated' when an intervention such as DBT is offered. Identifying the agent of change is therefore an important consideration to determine the effectiveness of an intervention. The current research found that from service user perspectives, common factors played an important role in the identified benefit from therapy, rather than specific DBT related factors. This is consistent with previous research in the area of common versus specific factors, and also consistent with questions regarding the appropriateness of the current medical model approach to offer a specific therapy for a specific disorder (Messer & Wampold, 2002). However, as noted previously, not offering an intervention can lead to an escalation in presenting difficulties (Miller, Neft et al., 2008). It is therefore important to offer an intervention for this adolescent population that is flexible enough to meet individual needs. In light of the benefit of peer support found in this study, it is possible that facilitating a peer support group would be an effective and more cost effective intervention.

4.3 Methodological Limitations

The findings from this study need to be evaluated and interpreted in light of its methodological limitations, namely related to the design, sample and interviews.

4.31 Design

Semi-structured interviews were analysed using thematic analysis from a realist perspective in order to explore adolescents' individual experience of participating in DBT. Whilst this fit with the exploratory nature of the study, it is important to consider objectivity with such a realist epistemology. As such, to remain unbiased the researcher should not impose meaning on to the data being analysed. Whilst the researcher attempted to approach the data with limited preconceptions, it is difficult to remain completely objective with qualitative research and consequently alternative interpretations are possible. In order to reduce the potential for such bias and to consider alternative explanations, the data were validated at numerous time points, as highlighted in Chapter Two. In addition, the use of direct quotes allows the reader to further validate the interpretations made. However it was not possible to have the data and the interpretations made validated by the participants themselves. This would have been helpful to ensure the themes were an accurate reflection of the participants' experience and is therefore an important consideration for future research.

4.32 Sample

All adolescents who had attended the DBT programme were invited to participate in the current study. However they did not all choose to take part in the research and as such the sample size for the current research was relatively small. Whilst it would have been preferential to have a larger amount of participants, qualitative research often has small numbers due to the amount of data collected from each individual, and it has been argued that whilst twelve participants is an ideal number for thematic analysis, it is possible to construct themes with up to six participants (Guest, Bunce, & Johnson, 2006). The current study had a sample of five participants which whilst small, resulted in a large amount of data from which the themes were constructed.

As mentioned previously, the sample was recruited from a pilot DBT site; as such this was the therapists' first experience of delivering DBT. It is important to consider any implications the therapists' inexperience with delivering DBT may have had on the participants. Indeed, as noted in Chapter three, therapist factors contributed to both positive and negative experiences. Therapist skill at delivering the material was found to be positive; however it appears overall it was delivered in a programmatic way which did not suit the needs of many of the participants. Whilst the results should be interpreted in light of the therapists' relative inexperience with DBT, it is important to note that the current study offers an insight into the experience of receiving DBT in routine clinical practice.

In addition, as with any study it is possible there were differences between those who took part and those who did not. For example although male adolescents were involved in the DBT programme, none chose to participate in the research. As noted in the literature this is an under researched group in relation to BPD and DBT and further research in this area would be beneficial to clinical practice. It would also be helpful to explore the reasons why some participants choose to participate whilst others do not. As noted previously communication difficulties are an inherent problem for people with BPD and it could be those who do not participate struggle more in this area. If this is the case then rapport building would be an important consideration.

It may be that professionals who already have a relationship with the adolescents are best placed to conduct interviews and gather data, in an effort to overcome communication barriers with this population. In addition consideration should also be given to the benefits of data being collected by adolescents who have previously participated in DBT. This may help increase engagement, particularly as participants in the current study described talking to their peers as a positive experience.

4.33 Interviews

Due to time constraints the semi structured interview was piloted with colleagues rather than a clinical sample. It is possible a pilot with adolescents would have resulted in changes to the interview schedule. In addition due to the nature of the interviews there was little time to build rapport with the participants and as discussed previously this sample has difficulties with communication; this may therefore have impacted on participants' disclosure during the interview. Indeed at times the researcher felt that participants found it difficult to talk about their difficulties and thus required a sensitive approach. Whilst concerns relating to disclosure are inherent in all research, the difficulties engaging with this client group again suggests that rapport building and choice of interviewer are important considerations for future research in this area.

4.4 Clinical Implications

DBT is the treatment of choice for adults with BPD due to the evidence supporting its use; however the research for adolescents is limited although this intervention is used in clinical practice. Developing our understanding of participants' experience of therapy helps us to tailor and develop interventions to help meet individual need. This is integral to the role of a Clinical Psychologist and it is important to ensure interventions offered are supported by research evidence.

The current study therefore has direct clinical implications, foremost to the service involved in the study but also to other services offering DBT to adolescents. The findings from this study add to the growing body of research on the effectiveness of DBT when used with adolescents. The adolescents in this study report finding little benefit from DBT specifically, with positive narratives relating more to factors common to all therapies. In light of this it is

important for services to consider how they are meeting the needs of adolescents who present with BPD traits. It appears the need for additional or alternative interventions should be an important consideration. Clinical Psychologists could play an important role in such considerations and are well placed to evaluate the interventions offered in their service and offer supervision and consultation to others providing therapeutic interventions.

4.5 Future Research

As the current research was exploratory in nature and as there is limited research on the use of DBT with adolescents, more research in this area generally is needed. It would be helpful for this study to be replicated to ascertain whether adolescents receiving DBT in other services are similarly disappointed by their therapy outcome. In addition as some participants reported finding some benefit from DBT skills it would be helpful to explore these mixed findings further to ascertain what factors contribute to a more positive experience.

More specifically, based on the findings from this study, it would be helpful for future research to explore whether trauma related work or a peer support group would be helpful interventions for adolescents with BPD traits. In addition future research to develop our understanding of the difficulties engaging this client group would be useful.

4.6 Reflexivity

The process of the research is important to reflect upon in qualitative research, particularly when a realist epistemology is utilised, as whilst it is important to remain objective throughout the research process I will bring to it my own beliefs about BPD and DBT. Prior to completing this research study I had only worked with adults with a diagnosis of BPD and

had limited experience of DBT. Through my past experience with adults I had learnt that their difficulties had been present for many years and as such they would have liked psychological intervention sooner, for example in their teenage years. At the time of commencing the research I therefore had a belief that early intervention would be beneficial for individuals with BPD traits. I also felt that DBT would be the most beneficial therapeutic approach due to my awareness of the literature in this area.

I feel I began this journey with a naïve and biased perspective and have learnt a lot throughout this research process. I envisioned the adolescents taking part in the research would talk to me about the benefits of therapy and how their difficulties had improved. Whilst positives were noted, there were also many negatives about their therapy experience. Listening to the different experiences along the way left me feeling many emotions, for example; disappointed DBT did not live up to my expectations, angry that services were not able to offer more but also happy and proud of some of the achievements and improvements made.

The task of research was daunting from the outset due the time restrictions and difficulties with recruitment. The need to analyse data rich interviews was also daunting particularly as I had little previous experience in completing qualitative research. On reflection, I feel my limited experience was an advantage as I did not have any pre-conceived ideas or expectations about what the themes or thematic maps should look like. I felt this qualitative approach allowed me to be more in touch with the data and the findings in comparison to a quantitative design. As such I found a shift from being daunted by the task of analysis to instead enjoying the process!

Throughout my qualitative journey I reflected on a number of issues I noted in the accounts, mainly the adolescents' desire and desperation for improvement in their difficulties, yet the difficulties in achieving such a change. DBT is a comprehensive and expensive package, yet for these adolescents, it was felt to have done little for their multiple and varied difficulties. This process therefore left me with many questions such as should services offer DBT? Is adolescence the best time to offer DBT? Would a support group be more beneficial? Should a more individualised treatment package be offered? What else can services do to support this client group with their difficulties? Whilst I feel this study has been beneficial in contributing to the research exploring the use of DBT with adolescents with BPD traits, I believe much more research is needed before the question of 'what works' with this client group can be answered.

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CHAPTER ONE: INTRODUCTION

This chapter explores the available intervention options for the population and the recommended Therapy (DBT). The literature explores adolescent experience the aims and objectives of the research.

1.1 Personality

Personality is currently understood as a complex combination of various traits which are unique to each individual (Livesley, 2001). Personality researchers over the past 40 years have consistently found that personality can be best understood through five broad factors;

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